LOUISIANA FY 2010
BLOCK GRANT PLAN

Part C
STATE PLAN
Section III

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

ADULT PLAN

EMERGENCY RESPONSE

The State of Louisiana continues to recover from hurricanes that have changed the way that mental healthcare is delivered in the state. The state was obviously challenged by Hurricanes Katrina and Rita in 2005. Then after a short reprieve, the Louisiana gulf coast was hit again in September of 2008 by Hurricane Gustav. Gustav hit the region to the west of New Orleans, squarely targeting the metropolitan Baton Rouge area; including the Office of Mental Health administrative headquarters and the heart of the government for the entire state. Following on the heels of Gustav, Hurricane Ike impacted the area of the state previously affected by Hurricane Rita.

Hurricane preparedness, response and recovery have become a part of every healthcare provider's job description, and employees have learned that every disaster is different, often requiring new learning and flexibility. As an example, employees of OMH are now on standby alert status should a storm threaten the coast, and all employees are expected to be active during a crisis. All Louisiana families are encouraged to *"Get a Game Plan"* (http://getagameplan.org/) in order to be prepared for a hurricane, should one strike. Clinicians in mental health clinics have made a point of discussing disaster readiness with clients to ensure that they have needed medications and other necessities in the case of an evacuation or closed clinics.

Although 'Emergency Response' in the state has become somewhat synonymous with hurricane response, the lessons learned from the hurricanes apply to disaster response of any kind.

Louisiana Spirit Hurricane Recovery Crisis Counseling Program

Louisiana Spirit is a series of FEMA/SAMHSA service grants funded through the Federal Emergency Management Agency and administered through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The Louisiana Office of Mental Health was awarded a federal grant for the Crisis Counseling Assistance and Training Program (CCP) in Louisiana, which focuses on addressing post hurricane disaster mental health needs and other long term disaster recovery initiatives, in coordination with other state and local resources. Crisis Counseling Programs are an integral feature of every disaster recovery effort and Louisiana has used the CCP model following major disasters in the state since Hurricane Andrew in 1992.

The CCP is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA). Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974 authorizes FEMA to fund mental health assistance and training activities in areas which have been Presidentially declared a disaster.

These supplemental funds are available to State Mental Health Authorities through two grant mechanisms: (1) the Immediate Services Program (ISP) which provides funds for up to 60 days of services immediate following a disaster declaration; and (2) The Regular Services Program (RSP)

that provides funds for up to nine months following a disaster declaration. Only a State or federally-recognized Indian tribe may apply for a crisis counseling grant.

In the fall of 2008, upon receiving the Presidential disaster declaration for Hurricane Gustav, OMH conducted a needs assessment to determine the level of distress being experienced by disaster survivors and determined that existing State and local resources could not meet these needs. Fifty-three parishes were declared disaster areas for Gustav; they were awarded in four separate declarations as the State appealed the decisions. Louisiana immediately applied for a Crisis Counseling grant for Gustav while in the process of phasing down the Katrina and Rita grants. The grant was awarded in late September of 2008.

Disaster mental health interventions include outreach and education for disaster survivors, their families, local government, rescuers, disaster service workers, business owners, religious groups and other special populations. CCPs are primarily geared toward assisting individuals in coping with the extraordinary distress caused by the disaster and connecting them to existing community resources.

The CCP does not provide long term, formal mental health services such as medications, office-based therapy, diagnostic and assessment services, psychiatric treatment, substance abuse treatment or case management; survivors are referred to other entities for these services. CCPs provide short-term interventions with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. Community outreach is the primary method of delivering crisis counseling services and it consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Crisis counseling services include: Information/Education Dissemination, Psychological First Aid, Crisis/Trauma Counseling, Grief & Loss Counseling, Supportive Counseling, Resiliency Support, Psychosocial Education, and Community Level Education & Training.

The Louisiana Spirit Hurricane Recovery program is currently operating under the Gustav grant and employs a diverse workforce of up to 276 staff members. Approximately 200 of these positions provide direct outreach service in the communities. Under Gustav, there are currently seven service areas which roughly cover the same geographic areas as the Office of Mental Health's regions/districts. The majority of the staff consists of unclassified state employees. Management and oversight of the program is provided by a state-level executive team dedicated to the support of all operations of the project.

Louisiana Spirit is designed to facilitate integration with other recovery initiatives, rather than compete with them. Therefore, the Louisiana Spirit state-level organizational structure is designed to continuously be in contact with recovery initiatives throughout Louisiana and coordinate its activities with these other recovery operations. Under Hurricane Gustav, there are fewer resources available to assist with hurricane related needs than were available after Hurricane Katrina in 2005. Each service area continuously strives to keep up with changing community resources to share with survivors and other community entities. When long term recovery committees exist within a service area, Louisiana Spirit makes the needs of survivors known to the participating entities.

The goal of Louisiana Spirit is to deliver services to survivors who are diverse in age, ethnicity, and needs. Extensive ongoing evaluation of the program includes assessment of the services provided, the quality of the services provided, the extent of community engagement, and monitoring of the health and recovery of the entire population. The evaluation plan for Louisiana Spirit is

multifaceted to reflect the ecological nature of the program seeking to promote recovery among individuals, communities, and the entire population of Louisiana. The assessment component of Louisiana Spirit hopes to answer the question of not only the absolute number of people served but how the services are distributed across geographic areas, demographic groups, risk categories and time. To this end, each of the state-level administrative staff members is responsible for ensuring fidelity to the CCP model and expectations as directed by SAMHSA/ FEMA.

SAMHSA/ FEMA also requires CCPs to collect information to provide a narrative history-a record of program activities, accomplishments and expenditures. Louisiana Spirit collects data on a weekly basis from all providers which is analyzed by the Quality Assurance Analyst and also sent to SAMHSA for further analysis and comparison with data from all the other Immediate Services Program and Regular services Program Crisis Counseling Programs in the nation. The different service areas compile a narrative report to Louisiana Spirit headquarters on a bi-weekly basis. From Gustav's inception in September 2008 through June 14, 2008, a total of 293,842 face-to-face services have been provided. 62,233 of these were individual contacts lasting over 15 minutes, 191,299 of these were brief contacts lasting less than 15 minutes and 40,310 contacts were classified as participants in groups.

To help to monitor geographic dispersion/reach/engagement, the number of individual and group counseling encounters for a given week/month/quarter are tallied by zip code and displayed graphically as a check of whether communities are being reached in accord with the program plan and community composition. To monitor demographic dispersion/reach/engagement, the individual encounter data has been broken down by race, ethnicity and preferred language as one indicator of how well the program is reaching and engaging targeted populations.

Federal funding for the Louisiana Spirit Gustav program is scheduled to end January 12, 2010. Since hurricane related needs and community capacity to meet those needs are assessed on an on-going basis, the program will be phased out in stages based on need. The table below outlines more specifically the services provided with the Gustav program through May of 2009.

Louisiana Spirit - Hurricane Gustav Services
10/1/08 through 5/31/09

Summary of Services Provided to Child, Youth and Elderly Populations

10/1/08 to 5/31/09	**Individual (ICC)**	**Group Sessions**	**Group Participants**
Children and Youth	**895**	**267**	**2,252**
• (0 to 5 years)	• 134	• 21	• 324
• (6 to 11 years)	• 192	• 126	• 961
• (12 to 17 years)	• 569	• 120	• 967
Elderly (65+ years)	**6,757**	**107**	**1,942**

Access Program

The Access Program is a new community-based counseling program that operates through the Department of Health and Hospitals, Office of Mental Health. The program was created during the review and evaluation of the state's mental health disaster response, post-Katrina; and was a direct response to the lingering mental health crisis. Funding for the program was allocated by the Governor's Office to build a more immediate response to citizens in need of emotional and behavior health services. Access team members provide emotional and behavioral health specialized crisis counseling services to citizens in crisis throughout the New Orleans metropolitan area; which includes Orleans, St. Bernard and Plaquemines parishes.

The goal of Access is to serve citizens (including children, youth and families) in the community, acting as a transition between the initial crisis and through the waiting period, prior to receiving assessment and treatment services for mental health related issues. The Access Program also has provided citizens with a swift support service response that often prevents emotional crises from escalating, while often negating the need for hospitalization. Access ultimately serves clients well and saves the state millions of tax payer dollars. Access accepts referrals from recovery organizations, community centers, public health clinics and the private sector.

The program uses a team approach, using dyads consisting of a master's level Crisis Counselor, specializing in social work or counseling, and a paraprofessional Resource Linkage Coordinator. Together these dyads provide immediate crisis intervention support and resource information; with a focus on empowering the client to regain control of their life, develop self-help skills to manage future crises, and avoid disruptive and costly hospitalization. All of the services provided by the Access team take place in the client's home or in a community-based location.

The Access teams provide individual & group counseling support services for persons in need who would not have easily had direct access to emotional and behavioral health services. Often these individuals and families are uninsured, underinsured, poor, homeless / at risk of becoming homeless, elderly, single and pregnant, adjudicated (youth & adults), substance abusers and/or wayward at-risk youth.

Access has established networks with homeless and domestic violence shelters/ missions, public health clinics, youth training centers, community centers, churches, residential facilities, juvenile justice programs, public schools, food banks and many other community support organizations, encountering approximately 25,000 individuals between December 2008 and June 2009.

HEALTH, MENTAL HEALTH, MH REHABILITATION SERVICES & CASE MANAGEMENT

FY 2010 - ADULT PLAN

Individuals with Serious Mental Illnesses often have co-occurring chronic medical problems. Therefore, it is important to enhance a collaborative network of primary health care providers within the total system of care. The Office of Mental Health continues to develop holistic initiatives that offer comprehensive and blended services for vulnerable children and adults experiencing psychiatric and physical trauma, including those in acute crisis. In addition, Louisiana's extensive system of public general hospitals provides medical care for many of the state's indigent population, most of whom have historically had no primary care physician. Over the past few years, OMH's acute psychiatric inpatient services have been moved under the Louisiana Health Sciences Center-Health Care Services Division (LSUHSC-HCSD), and LSU Shreveport public general hospitals. It is believed that continuity of care is often better served under LSU and that those persons admitted with acute psychiatric problems might then receive the best *physical* assessment and treatment as well as care for their psychiatric problems. Adults who are clients of state operated mental health clinics or Medicaid funded Mental Health Rehabilitation (MHR) Services also benefit from a systematic health screening. Further, MHR providers who provide services to children, youth, and adults must assure through their assessment and service plan process that the whole health needs of their clients are being addressed in order to get authorization for the delivery of services through the Medicaid/OMH Behavioral Healthcare Unit. The OMH clinics work very closely with private health providers as well as those within the LSUHSC-HCSD.

Outpatient mental health services have historically been provided through a network of approximately 43 licensed community mental health clinics (CMHCs) and their 27 outreach clinics. These are located throughout OMH geographic regions and LGEs. The CMHC facilities provide an array of services including: screening and assessment; emergency crisis care; individual evaluation and treatment; medication administration and management; clinical casework services; specialized services for children and adolescents; and in some areas, specialized services for those in the criminal justice system.

The CMHCs serve as the single point of entry for acute psychiatric units located in public general hospitals and for state hospital inpatient services. All CMHCs operate at least 8 a.m. - 4:30 p.m., five days a week, while many are open additional hours based on local need. CMHCs provide additional services through contracts with private agencies for services such as Assertive Community Treatment (ACT) type programs, case management, consumer drop-in centers, etc. OMH is cognizant of the fact that some of these services are limited and not available statewide, and efforts to improve access are constantly being made.

Although the CMHC's operate with somewhat traditional hours, crisis services are provided on a 24-hour basis. These services are designed to provide a quick and appropriate response to individuals who are experiencing acute distress. Services include telephone counseling and referrals, face-to-face screening and assessment, community housing for stabilization, crisis respite in some areas, and access to inpatient care.

The Mental Health Rehabilitation (MHR) program continues to provide services in the community to adults with serious mental illness and to youth with emotional and behavioral disorders. The MHR program remained under the management of the Office of Mental Health through June 30th,

2009, but as of July 1, 2009, the oversight and management of the program was transferred to the Bureau of Health Services Financing (Medicaid) within DHH. All staff, equipment, materials, contracts, purchase orders, processes and personnel were transferred. Starting on that date, Medicaid began to provide all utilization management, prior authorization, training, monitoring, network, and member service activities. Consolidating the MHR program within the Medicaid Division will hopefully affect the delivery of services in a positive manner.

During the just ended fiscal year, the MHR program continued to refine its operation, oversight and management activities to align itself with industry standard Administrative Service Organization functions, including Member Services, Quality Management, Network Services (Development and Management), Service Access and Authorization, as well as Administrative Support and Organization.

Efforts to improve the Mental Health Rehabilitation optional Medicaid program continued through FY 2008 -2009. Collaborative relationships and projects with the Office for Community Services and the Office of Juvenile Justice resulted in a series of staff trainings and pilot projects across the state to increase access to medically necessary mental health services for eligible adults and children served by those agencies. Additional policies and procedures governing the processes of certification and recertification were developed. The moratorium on new provider enrollment/certificates was lifted beginning August 2007, with new providers enrolling in March 2008. As of the date of this summary, 12 additional providers have enrolled, expanding the network of qualified providers to 68. The total number of recipients served has continued to increase accordingly, resulting in approximately 7,387 unduplicated recipients having been served during the fiscal year.

MHR administration and leadership also began development of a comprehensive quality review tool for routine sampling of all providers and eventual publication of provider report card data. In addition, enhancements to the tools used to track provider status with regarded to certification, recertification, Program Integrity referrals, Attorney General referrals, outstanding deficiencies, plans of corrections, and accreditation status were developed and implemented. A provider training video was developed to increase provider competency and clinical skills knowledge base in Contingency Management for the youth population. This video series was made available to all providers free of charge. The MHR Website was significantly overhauled and equipped with enhanced distance learning capabilities, including the capacity to provide for pre- and post-testing in support of online training for the provider network.

Quarterly sessions with providers were continued both in person around the state and via telecommunication, and all authorized providers in the network remain accredited by JCAHO, CARF, or COA, a requirement of the program that began on March 31, 2006.

The tables below show pertinent facts about the MHR program through FY 2009, the final year that MHR will be housed in the Office of Mental Health.

Number Receiving Mental Health Rehabilitation Services

	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09
Children: Medicaid Funded	3,961	5,080	4,886	4,201	4,539	5,205
Adults: Medicaid Funded	2,265	2,506	2,379	1,605	1,459	2,182
TOTAL	6,226	7,586	7,265	5,806	5,998	7,387

Mental Health Rehabilitation Providers

	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09
Medicaid Mental Health Rehabilitation Agencies Active During FY	128	124	114	77	61	68

EMPLOYMENT SERVICES
FY 2010 - ADULT PLAN

The Office of Mental Health (OMH) recognizes that work is a major component in the recovery process and supports consumers who have work as a goal. OMH has utilized Employment Specialist training and other related employment training available through The University of North Texas & the Federal Region VI Community Rehabilitation Continuing Education Program to build a cadre of trained Employment Coordinators in each Region. At this time however, most Regional Employment Coordinators have additional duties and on average devote less than 25% of their time to employment issues. This has served to hamper OMH efforts to increase employment initiatives. Several regions have expressed an interest in hiring full time employment coordinators and are working towards doing so.

To expand employment of persons with severe mental illness, OMH has promoted a strategy to actively seek and access opportunities external to OMH at the state and federal level to fund the further development of such services which expand employment opportunities. Such external opportunities may include, but are not limited to monies available for employment, employment services related to housing support, vocational rehabilitation services, and related employment services. Such funds are available through the Social Security Administration, HUD, Department of Labor WorkFORCE Development, the Rehabilitation Services Administration, and other Federal and state programs. The passage of the Federal Ticket to Work Program and the Work Incentives Improvement Act of 1999 make a large pool of federal dollars available for development of these employment related services.

OMH also has active linkages to, and representatives serving on the advisory bodies of, the Louisiana Medicaid Purchase Plan, Social Security Administration Benefits Planning Grant, Department of Labor One-Stop Accessibility Grant, Ticket-To-Work grant opportunities, and other employment related national and state public/private funding resources such as the WORK PAY$ committee. This committee is comprised of community partners and is intended to further the employment of individuals with disabilities in the state of Louisiana. OMH is also working as a collaborative partner on both a state and regional level in the development and implementation of job fairs for individuals with disabilities throughout the state. This will be the 6th year of the job fairs, which have traditionally been held in October for National Disability Employment Awareness Month.

OMH Employment Liaisons and Consumer Liaisons continue to receive training in Benefits Planning, One-Stop, and Ticket-To-Work topics relevant to mental health consumers through Social Security Benefits Planning and the Department of Labor. Staff members from the state vocational rehabilitation agency, Louisiana Rehabilitation Services State Office (LRS), and members of the field staff attend these meetings and trainings. University of North Texas has been brought to Louisiana to train both LRS and OMH staff on issues related to employment, recovery and evidence based practices. This joint training is done on a regional basis and in addition to education is intended to strengthen relationships and overcome any barriers to successfully collaborating on the employment of individuals with psychiatric disabilities.

Louisiana Work Incentive Planning and Assistance (LAWIPA)

The Louisiana Work Incentive Planning and Assistance (LAWIPA) program helps Social Security beneficiaries work through issues relating to social security benefits and employment. The program is a coalition between the Advocacy Center of Louisiana and the LSU Health Sciences Center's Human Development Center. Many individuals with disabilities who receive SSDI and/ or SSI benefits want to work or increase their work activity. One barrier for these individuals is the fear of losing health care and other benefits if they work. Valuable work incentive programs can extend benefits, but are often poorly understood and underutilized. The LAWIPA coalition will educate clients and assist in overcoming work barriers, perceived or real; and will also focus on improved community partnerships. Benefit specialists, called Community Work Incentive Coordinators, provide services to all Louisiana SSDI and SSI beneficiaries age 14 and older who have disabilities. CMHC staff and clients are able to work with Coordinators to help navigate the various work related resources (as offered in conjunction with the Ticket to Work program), and identify on an individualized basis the way their benefits will be impacted by going to work. The ultimate goal of the new WIPA coalition is to support the successful employment of beneficiaries with disabilities.

OMH has participated in the development and implementation of Supported Self-Employment (Micro enterprise) pilots in different regions of the state, and in the previous development and establishment of intensive employment placement and support pilots (Employment Recovery Teams) in two regions. OMH has also supported the continued implementation of an employment program through the Jefferson Parish Human Services Authority's community mental health clinic. The program continues with great success as the JPHSA staff collaborates with LRS, DOL and the Career Solution Centers, as well as actively works with their clinician pushing employment as a path to recovery.

Joint OMH-LRS efforts are aimed at offering consumers intensive individualized supports in order to assist them in seeking, finding, obtaining, and keeping employment in community based competitive jobs and/ or self-employment. A joint LRS-OMH agreement spells out each party's areas of responsibility and supports regular collaboration between the agencies. OMH has conducted Employment Needs Assessments with collaborative participation by LRS in each Area, and engages in routine joint regional meetings to: assess each Area's current employment initiatives; determine needs for enhancement/creation of new employment programs/opportunities for consumers; share information on current and planned OMH employment projects; develop/enhance cooperation with LRS and private employment providers; develop a database of employment related resources for each Region/Area.

Initiatives in line with the *Presidents New Freedom Commission* Report and the Louisiana Office of Mental Health's mission, OMH continues to work on the implementation of recommendations outlined by several employment workgroups through policy/program development and collaboration with community partners. The workgroups include the Louisiana Commission on the Employment of Mental Health Consumers; and although the Commission was sunsetted in 2007, the recommendations continue to be relevant.

Act 378 funds for adults are limited to those who have been hospitalized for at least 18 months and are ready for discharge. These funds can be used in any manner to assist the individual in remaining in the community. Should they need any type of job training or assistance in obtaining a job, or a job coach, these funds can cover those costs.

In September 2008, Hurricane Gustav left the CAHSD geographical service area with tremendous devastation that resulted in widespread power outages, malfunctioning or missing traffic lights, downed trees blocking roadways, and structural damage to buildings as well as homes, which in turn delayed some clients in being able to return to work and caused some employers to close their businesses. Clients with severe mental illnesses who are served by the Louisiana HIRE, an IPS program in CAHSD, are slowly returning to work as businesses re-open. Some local businesses and homes still sport blue tarps on their roofs as they continue to await repairs. Individuals that become clients of CAHSD mental health services are eligible for services from the La HIRE program that provides team building and intensive employment support. Services include case management, job finding, and other supportive services necessary to help consumers find and maintain employment. In January 2009, CAHSD filled its Employment Coordinator position and developed a new District-wide Employment Program to meet the employment needs of transition age youth and adults with emotional disorders/behavioral disorders, severe mental illnesses, addictive disorders, developmental disabilities, and co-occurring disorders, particularly those who are not served by the LAHIRE program.

In January 2009, CAHSD filled its Employment Coordinator position and developed a new District-wide Employment Program to meet the employment needs of transition age youth and adults with emotional disorders/behavioral disorders, severe mental illnesses, addictive disorders, developmental disabilities, and co-occurring disorders, particularly those who are not served by the LAHIRE program.

A Work Experience (WE) Program site for JOB 1, a program of Goodwill Industries of Southeastern Louisiana, Inc. is located in MHSD, and is part of the Mayor of New Orleans' Economic Development Team. WE provides on-the-job training for persons with limited or no previous work experience in an effort to help them develop basic work readiness skills, as a part of their effort to find permanent employment.

The overall goal of OMH employment initiatives is to create a system within the Office of Mental Health that will encourage and facilitate consumers of mental health services to become employed, thereby achieving greater self-determination and a higher quality of life, while helping consumers transition from being dependent on taxpayer supported programs; to being independent, taxpaying citizens contributing to the economic growth of our state and society. The national economy has made this goal an extremely challenging one at best. Nationwide, a suffering economy can have a spiraling effect as workers are laid off and the need for public assistance increases. However, when resources are not available, the solution-focused alternative is to assist clients in obtaining and maintaining employment through help with resume-writing, job searching, and interviewing skills.

Employment Programs Serving SMI by Region – FY 2009

REGION / LGE	TYPE OF EMPLOYMENT SERVICE	NUMBER SMI SERVED	NUMBER SMI PLACED
MHSD	Employment/Pre-Employment Training Supported Employment Individual Placement and Support (IPS)	67	6
CAHSD	Individual Placement and Support (IPS)	41	32
III	Employment/Pre-Employment Training	479	64
IV	Supportive Employment Transitional Employment	22	22
V	Employment Referral Employment/Pre-Employment Training	97	unknown
VI	Consumer Micro Enterprise Employment Referral Employment/Pre-Employment Training, Supported Employment Transitional Employment Individual Placement and Support (IPS)	89	15
VII	Employment Referral Employment/ Pre-employment Training Supported Employment Transitional Employment, Individual Placement and Support (IPS)	179	38
VIII	Transitional Employment Individual Placement and Support (IPS)	115	54
FPHSA	Employment Referral Transitional Employment	61	1
JPHSA	Supported Employment Individual Placement and Support (IPS)	107	46
TOTAL		**1257**	**278**

PROFILE OF PERSONS SERVED CMHC, ADULT CLIENTS BY EMPLOYMENT STATUS

LOUISIANA OMH COMBINED OUTPATIENT (ARAMIS & JPHSA) PERSONS SERVED UNDUPLICATED – FY 2009

	Age 18-20		Age 21-64		Age 65+		TOTAL		TOTAL
	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	
Employed: Competitively Employed Full or Part-time (includes Supported Employment)	145	102	3,031	1,820	37	15	3,213	1,937	5,150
Unemployed	183	159	3,170	2,772	44	41	3,397	2,972	6,369
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled,etc)	560	563	14,977	9,985	994	390	16,531	10,938	27,469
Employment Status Not Available	33	35	548	413	22	8	603	456	1,059
TOTAL	921	859	21,726	14,990	1,097	454	23,744	16,303	40,047

Employment status at admission. Excludes JPHSA. Unduplicated within program type (Outpatient).
URS Table 4.
DATA SOURCE: ARAMIS casedate.sas 7/21/09

HOUSING SERVICES
FY 2010 - ADULT PLAN

As with employment services described previously, the MHR, case management, and ACT programs are very involved in assisting consumers and families with opportunities to secure and maintain adequate housing. Furthermore, in keeping with the use of best practices and consumer and family choice described in Criteria 2 and 5 of the *President's New Freedom Commission Report*, OMH has a strong commitment to keeping families together, and to increasing the stock of permanent supportive housing; and consequently has previously withstood pressure to fund large residential treatment centers. Instead, effort and dollars have been put into Family Support Services, housing with individualized in-home supports, and other community based services throughout the state. The consumer care resources provide highly individualized services that assist families in their housing needs. OMH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has actively pursued the inclusion of people with disabilities in all post-disaster development of affordable housing. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed through a combination of disaster-related housing development programs (including Low Income Housing Tax Credits) targeted to low income people with disabilities. Congress approved funding for 3,000 rental vouchers to go to participants in the PSH program, furthering the goal of serving 3,000 people and their families. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative will also target the aging population so those persons with mental illness who are in that subpopulation will have targeted housing.

In 2008, a plan was developed by the Department of Health and Hospitals to provide immediate assistance to the mental health delivery system in New Orleans that had continued to struggle post-Hurricane Katrina. One of the items in the plan was a rental assistance program that funded 300 housing subsidies for individuals; some of whom are homeless with serious mental illness and co-occurring disorders. Of particular note has been the OMH pursuit of State General Funds for housing and support services. OMH was successful in obtaining initial funding sufficient to develop housing support services for 600 adults with mental illness (60 for each of the 10 planning regions) and 24 hour residential care beds to serve 100 people (10 for each of the 10 planning regions) in 2006. This program was successfully continued through FY 2008-09.

During FY 2008-09, state general funds supplied approximately $7 million in funding for housing and support services for adults statewide. These funds are used for adult residential care, adult permanent supportive housing, supervised independent living, drop-in centers, transitional living programs, crisis housing, respite programs and comprehensive supports and services.

The state has continued to pursue housing resources through the HUD funding streams such as the Continuum of Care for the Homeless program and the Section 811 and Section 8 programs over the past ten years. While shifts in HUD policy have created barriers to persons with mental illness qualifying for housing resources through the Continuum of Care, and the Section 811 and Section 8 programs have been severely reduced, the HUD programs continue to be a focus of development activities. OMH Regional Housing Coordinators are active participants in the regional housing/homeless coalitions. In some cases these coordinators are in leadership positions in their local coalitions. Service providers have pursued Section 811 applications and sought to develop fruitful relationships with local housing authorities to pursue rental vouchers. Federal applications

for housing and support services submitted by mental health providers have increased over the years as agencies search for avenues to develop housing and support services for the mental health consumers they serve.

There is much activity around assisting individuals with SMI to obtain and maintain appropriate housing. Many successful programs to assist individuals with housing needs are operating in each Region and LGE as can be seen in the table below:

Housing Assistance Programs by Region/ Local Governing Entity (LGE) FY 2009

Region/ LGE	# of Programs	# Referred Unduplicated	# Placed Unduplicated
MHSD	Not available	Not available	Not available
CAHSD	8 programs	141	90
Region III	9 programs	617	161
Region IV	5 programs	Unknown	176
Region V	10 programs	450	195
Region VI	8 programs	292	78
Region VII	7 programs	89	123
Region VIII	6 programs	75	45
FPHSA	5 programs	Unknown	unknown
JPHSA	10 programs	981	699

Although the hurricanes of 2005 displaced a record number of people to localities outside of Louisiana, the number of homeless people with mental illness is not reduced along with the reduction of the general population. Instead, the number of homeless individuals is slightly larger than pre-disaster estimates would indicate. An already critical shortage of affordable housing was exacerbated by the hurricanes. This is true of the general population in Louisiana and the resulting demand has escalated housing costs further.

The annual reports from Louisiana Projects to Assist in Transition from Homelessness (PATH) providers show that 4,871 homeless persons with mental illness were served in the fiscal year 2008 with Federal and matching PATH funds and other sources of funding. Annual data reported by PATH providers for the number of individuals enrolled in PATH in 2008 was 2,048 (unduplicated count). This is less than the number identified through the shelter system with one possible explanation being that PATH is not a statewide program. UNITY of Greater New Orleans, a non-profit organization for the homeless, estimates that there are approximately 12,000 homeless persons on any given day in the Greater New Orleans area alone who are in need of housing and supportive services, and approximately 40% or 4,800 have a mental illness.

This is in stark contrast to the most recent Point in Time (PIT) survey (2007), in which the total number of literally homeless persons in all of Louisiana was 5,994. Literally homeless persons are those who live in emergency shelters or transitional housing for some period of time, or who sleep in places not meant for human habitation (streets, parks, abandoned buildings, etc.) and may use shelters on an intermittent basis. The PIT survey was a statewide count of homeless persons done during the 24-hour period between noon, January 30th and noon, January 31st.

UNITY states their estimation was based upon a multifactorial analysis including the PIT results, outreach statistics, and agency-reported requests for services as well as the demand for services

identified by the homeless population. It should be noted that the Point in Time survey is limited in its population coverage; for instance, unsheltered persons are difficult to identify and count, not all identified persons are willing to release information, and/or persons are undocumented because they do not seek services from a participating provider during the survey period. Therefore, by a conservative estimate, on any given day, there may be as many as twice the *reported* count of homeless adults and children living in Louisiana.

The face of homelessness changed in the New Orleans area due to the aftermath of Hurricanes Katrina and Rita in 2005, and Gustav and Ike in 2008. Many individuals and families experienced homelessness for the first time. In a recent (2009) article printed in Baton Rouge's daily paper, *The Advocate*, about 3,000 families who were left homeless after the hurricanes of 2005 are again looking for housing as their federal housing assistance comes to an end. According to FEMA, there are approximately 3,334 trailers or mobile homes still in use by hurricane evacuees. The Louisiana Family Recovery Corps, a Baton Rouge-based nonprofit created after the hurricanes to assist families was reported to be assisting another 14,600 families who continue to be in the federal Disaster Housing Assistance program which is to end on August 31, 2009.

Individuals with financial concerns, including many people with disabilities, are having an increasingly difficult time in retaining their housing and are at risk for homelessness. Those already homeless are facing significant barriers to obtaining housing they can afford. According to the National Low Income Housing Coalition, in Louisiana the Fair Market Rent for a two bedroom apartment is $788 per month. In order to afford this level of rent and utilities without paying more than 30% of income on housing, a full time work wage of $15.00 per hour is required.

Since 2005, the average SSI payment has increased 16.4% from $579 to $674 per month. During the same time period, the federal minimum wage level has increased 27.2% from $5.15 to $6.55. In contrast, the fair market rent for a 1-bedroom apartment, including utilities, in the Greater New Orleans area has increased 52.4% from $578 to $881. As a result, many consumers have been unable to maintain independent housing. Many of them live with family members or friends, often in overcrowded environments. Some of them end up in homeless shelters or on the streets because they are unable to stay permanently with family or friends. Some of them move around to different family and friends' homes, seeking assistance and services to help with stabilization.

It is difficult to estimate the number of people who continue to be affected by the hurricanes, because many of them have been in and out of different housing situations since the hurricanes occurred. The metropolitan areas around New Orleans continue to report severe problems, as do other areas affected by the hurricanes. The Greater New Orleans Community Data Center reports that, "due to damage to the existing housing inventory and the increase in demand for the remaining units, HUD continued to increase the Fair Market Rents for the seven-parish New Orleans area. The newest numbers, effective as of October 1, 2007 indicate that the average rent has increased by more than 46% since before Hurricane Katrina. Fair market rents are estimates of gross rental prices that include the cost of all utilities except phone and cable." JPHSA's Housing Coordinator has received approximately 300 calls during this past year from individuals who did not have previous contact. It is estimated that 70% of those individuals were affected by the hurricanes in some manner. Post- hurricanes, CAHSD reports a shortage of affordable rental housing and increases in poverty related to lack of livable wage employment. According to the Homeless Management Information System (HMIS) maintained by the Baton Rouge HUD Continuum of Care (Capital Area Alliance for the Homeless) a reported 1,994 households received post-disaster housing assistance from January 1, 2009 through May 31, 2009. Region 3 reported that housing

referrals were up by 16% this year due to damaged homes as a result of Hurricanes Gustav and Ike. The housing market has inflated and affordable housing is close to impossible to obtain in the area.

In summary, the need for housing services has increased, and available community placements have decreased due to the hurricanes. It is also noted that many evacuees are living with friends or family while waiting for housing; and thousands of people across the state are still in FEMA trailers.

NOTE: Please see *Criterion 4: Homeless Outreach* in this application, where many related issues, programs, and initiatives related to housing are discussed.

EDUCATIONAL SERVICES
FY 2010 - ADULT PLAN

Louisiana OMH Supported Education is a program based on a 1997 OMH/Louisiana State University (LSU) joint research project concerning theories and models of Supported Education nationwide, and development of a '*Louisiana Model*' for Supported Education based on that research. The Louisiana Office of Mental Health initially funded the LSU Supported Education Program for students with serious mental illness (SMI). In keeping with Goal #1 of the *President's New Freedom Commission Report*, stating that Americans understand that mental health is essential to overall health, supported education became a part of the disability program at LSU forcing recognition that mental health is as important as physical health to the well-being of college students. LSU became one of the first four year universities in the nation to have a supported education program in place and operational, with initiation of the program in 1997. Upon LSU's agreement to continue the program, OMH then moved the funding to the University of Louisiana at Lafayette (ULL). The ULL program became operational in the Fall Semester of 2000, with the University being fully able to sustain it internally as of 2006. Both LSU and ULL initially received funding with OMH Block Grant monies to establish a Supported Education Advisor position within each university's existing services for students with disabilities. The Supported Education Advisor only serves those students identifying themselves as persons with Serious Mental Illness (SMI) emphasizing that mental health care is consumer and family driven, as posited in the *President's New Freedom Commission Report*, Goal #2.

The OMH sponsored supported education programs provide both individual and group support to students with serious mental illness pursuing post-secondary education. Students also receive assistance with needed accommodations under ADA, as well as disability management counseling and information/referral to on and off campus agencies. The Supported Education Advisor serves as a case manager for students with SMI; is a liaison to the student's primary therapist; and serves as an on-campus advocate. The focus is on attempting to minimize the impact of a student's psychiatric illness by determining what accommodations are needed in order for the student to successfully handle both academics and adaptation to the social milieu of the university. The long-term goal of the program is to see the student with SMI successfully complete a university education and enter the world of work in a career field of the student's choice. The program targets students with SMI of all ages, both those who are older and are (re) entering a secondary educational setting after years of mental health treatment, as well as those who are younger and may be experiencing psychiatric symptomatology for the first time. Thus the goal of the program is achieved through both funneling individuals back into the educational system as well as maintaining them there as they cope with the onset of their mental illness. These goals fall in line with the

President's New Freedom Commission for Mental Health through its call for quality community based services, improved transition services and promotion of innovative and effective services such as supported education which are specifically targeted towards individuals with SMI.

Referrals to the program come from a variety of sources, including: OMH Mental Health Clinics, the on-campus Mental Health Services of the universities, Louisiana Rehabilitation Services, and University faculty and staff. The largest referral source, however, continues to be self-referral by SMI students enrolled at each school who have been made aware of the program. Satisfaction surveys administered to students receiving services at LSU and ULL indicate a high level of satisfaction with services received. Both schools continue to do satisfaction surveys with current students, and follow-up with those who have graduated. Grade point averages have consistently been above average, suggesting that the programs are working. For example, data from LSU indicates that there were 20 graduate students and 161 undergraduate students enrolled in the Supported Education program during the last year. Their grade point averages were 3.64 (graduate) and 2.76 (undergraduate).

Each university agrees to contribute in-kind resources for the program and to continue the programs funding once the OMH "seed money" ends, as well as to assist the transfer of supported education technology to other Louisiana institutions of higher learning. OMH continues to provide supports to LSU and ULL to ensure program efficacy, while strengthening capacity for serving this population in other institutions of higher learning.

OMH has made the Supported Education Program information available to other Louisiana post-secondary institutions, including the Community College system. OMH hopes to further expand this unique and excellent program to be available to all current and future students with SMI in the state who seek to succeed in obtaining a college education in order to access higher-level vocational endeavors and professions that such an education can provide.

Funds have been used to make available continuing education opportunities for the Supported Education Coordinators in the state. In addition, OMH sponsored a statewide seminar on supported education and best practices for serving this population through the various disability affairs offices. National leaders in Supported Education were brought in to present on topics related to needed supports/accommodations, education on supported education and fidelity to the model. The seminar was well received with representation from colleges and universities throughout the state.

The Louisiana Supported Education Program has been recognized as a best practice model, and has been noted nationally as an exemplary program. OMH has funded seminars to Louisiana university/ college Office of Disability Affairs staff in an effort to expand baseline competencies and to generate interest and improve services for individuals with psychiatric disabilities in the post-secondary educational setting. Additionally, OMH has begun the initial work necessary to develop a manual on Supported Education Services. The first step in development of the manual was a series of focus groups to identify the needs for several populations, including: 1) students with psychiatric disabilities; 2) their families; 3) office of disability affairs staff; 4) mental health clinicians; and 5) Vocational Rehabilitation Counselors who assist students with psychiatric disabilities go to school. The information gathered through the focus groups will result in a report which will be the basis of the development of the manual that will be disseminated statewide. OMH intends this product to improve services for students with psychiatric disabilities as well as lay the groundwork for additional supported education programs throughout the state.

SERVICES FOR PERSONS WITH CO-OCCURRING DISORDERS (SUBSTANCE ABUSE/ MENTAL HEALTH) AND OTHER SUBSTANCE ABUSE SERVICES

FY 2010 - ADULT PLAN

The Office for Addictive Disorders (OAD), a sister agency to OMH has traditionally offered treatment services to both adults and child /youth OMH consumers. As described earlier in this document, 2009 legislation creates the Office of Behavioral Health, combining the functions of the Office of Mental Health and the Office for Addictive Disorders. In some parts of the state OMH and OAD already jointly deliver services to people with co-occurring mental and substance disorders. While parallel or sequential treatment is still a common occurrence, the Louisiana Integrated Treatment Services (LITS) Model has been implemented in an increasing number of treatment facilities; and the restructuring of the Offices will aid in this treatment model becoming the norm. Co-occurring treatment ensures that emphasis is placed on early mental health screening, assessment and referral to services, and eliminating disparities in mental health services as noted in *The President's New Freedom Commission Report* Goals #3 and #4. Through the CoSig Grant, coordinated care is improving, with the commitment from each agency to work towards improving treatment for co-occurring disorders. OAD services include the following:

Outpatient Outpatient treatment services are defined as either:
outpatient or intensive outpatient based on the intensity of the services provided by the particular outpatient program.

Outpatient Treatment (Non-Intensive)

Treatment/recovery/aftercare or rehabilitation services are provided, but the client does not reside in a treatment facility. Clients receive alcoholism and/or drug abuse treatment services including counseling and supportive services, and medication as needed.

Intensive Outpatient Treatment/Day Treatment

Services provided to a client that last three or more hours per day for three or more days per week. A minimum of 9 treatment hours per week must be provided.

Inpatient This modality provides non-acute care and includes a planned and professionally implemented regime for persons suffering from alcohol and/or other addiction problems. It operates 24/7 and provides medical and psychiatric care as warranted.

Residential This is strictly a psychosocial model, based on a 12-step program with no medical or psychiatric care. The program functions 24 hours a day, seven days a week.

Detoxification There are two types of detoxification offered:

Medical detoxification

24/7 medical service providing immediate acute care for the alcoholic/substance abuser at extreme health risk (either from an illness/health problem co morbid with the substance abuse problem, or from medical problems resulting from the process of detoxifying).

Social Detoxification

24/7 service designated for patients who need immediate substance abuse detoxification treatment but are not facing any urgent health problems.

Community-Based Services

Halfway House Services

Provides community-based care and treatment for alcohol/drug abusers in need of transitional arrangements, support and counseling, room and board, social and recreational activities, and vocational opportunities in a moderately structured drug-free environment

focused on re-socialization and encouragement to resume independent living and functioning in the community.

Three-Quarter Way House Services

Less structured than a halfway house but provides a support system for the recovering alcoholic and/or substance abuser. Clients are able to function independently in a work situation. The three-quarter-way house functions as a source of peer support and supportive counseling. This level of service is designed to promote the maintenance of the client's level of functioning and prepare him/her for independent living.

Therapeutic Community (TC)

Highly structured environment designed to treat substance abusers that have demonstrated a pattern of recidivism or a need for long-term residential treatment. It is a unique program in that it relies on the social environment to foster change in the client while promoting self-reliance and positive self-image. In general, this program requires a minimum of 12 months duration.

Recovery Homes

Recovery homes are self-run and self-supported houses for recovering substance abusers. OAD supports this continuum of care by contracting with Oxford House, Inc., to establish and manage houses within designated areas of the State. In addition, OAD offers a revolving loan program to support the houses with start-up expenses.

Gambling Services

The Office for Addictive Disorders provides services to problem and compulsive gamblers. These services include the Compulsive Gambling Help Line, outpatient and inpatient treatment services, and compulsive gambling prevention services. The office also provides for research, training and program evaluation for the gambling addiction treatment and prevention community.

Louisiana has been a recipient of one of the Co-occurring State Incentive (COSIG) offered through SAMHSA. In addition, Louisiana has participated as one of ten states to participate in the first National Policy Academy on Co-Occurring Mental and Substance Abuse Disorders. The result of these initiatives has been a strategic plan to guide the development of co-occurring informed services throughout all service delivery inclusive of both adult and children services. Included in the action plan is the expectation that Louisiana citizens will be provided with an co-occurring system of healthcare that encompasses all people, who will easily access the full range of services, in order to promote and support their sustained resilience and recovery.

Critical steps in moving toward a co-occurring system of care included the development of a productive partnership between the Office of Mental Health and the Office of Addictive Disorders. The Louisiana version of the statewide co-occurring initiative is the Louisiana Integrated Treatment Model (LITS). The Louisiana Integrated Treatment Model (LITS) is organized around nine Core Principles (see below) originally delineated by Minkoff and Cline. According to this model, clinics are expected to adjust the delivery of their services across seven dimensions including: Program Structure, Program Milieu, Screening & Assessment, Treatment, Continuity of Care, Staffing, and Training.

The following nine guiding principles have been adopted to direct provision of services:

1. Dual diagnosis is an expectation, not an exception.

2. All individuals with co-occurring psychiatric and substance disorders (ICOPSD) are not the same; the national consensus four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level (NASMHPD, 1998).
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.
4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.
6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.
7. There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.
8. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.
9. The system of care operates in partnership with consumers, family members and concerned significant others and a continuous effort is made to involve the individual and the family at the system, program and individual levels.

The overarching goal of LITS is to move all ten of the major service delivery systems in Louisiana to a "Co-occurring Capable" status. "Co-occurring Capable" represents a measurable standard of care that was identified as a significant improvement, which can be designed and implemented locally through additional technical assistance and support. A "Co-occurring Capable" system would be created without significant clinical operational cost and could be reliably assessed through routine program evaluation with the identified fidelity instrument, Dual Diagnosis Capability in Addiction and Mental Health Treatment (DDCAT/ DDCMHT). The DDCAT/ DDCMHT provided an objective structure by which components of a co-occurring system could be defined and operationalized. The critical elements defined co-occurring capable program management, milieu, assessment, treatment, staffing patterns, and training. Use of the DDCAT/ DDCMHT provided a critical structure for local providers to objectively assess their current status, develop individual strategic plans, and establish an implementation plan.

A critical aspect of the CoSIG/ LITS initiative has been the development of an effective working relationship between the Office of Addictive Disorders and the Office of Mental Health at the state central office level, a local governance levels, and at the clinic level. Local steering committees comprised of mental health and addictive disorders staff were established at the local governance level to lead local planning, identify technical assistance needs, and guide implementation of integrated treatment services. System-wide and individual beliefs and barriers have been identified. Each group has evaluated the ability of the system to provide enhanced co-occurring informed services. Stakeholders are involved through the establishment of the Client Advisory Board, membership on the Behavioral Healthcare Task Force, and projects with community based organizations. Funding streams are being investigated to support drug screens conducted within the

OMH system, and increased physician and medication access in the OAD system. Clinical core competency standards are being developed to support integrated treatment, and on-going specialized support and training will be provided. Integrated management information and program evaluation systems, including a web-based client tracking system, are being developed. Cross agency screening and assessment instruments/protocols are being developed, including the ability to document two primary diagnoses.

OAD and OMH are working together to jointly develop a specialized Co-occurring residential unit. This unit will serve to fill a significant void for services that specifically address the complex and acute needs of persons with the combination of severe mental health and severe substance abuse disorders, otherwise conceptualized as the Quadrant IV persons on the Co-occurring Quadrant Model. In addition, some of the inpatient units within the existing state hospitals have taken on the challenge of creating a more co-occurring informed care delivery system.

Beginning with the summer of 2005 approximately 1,915 LGE and regional staff members from OMH and OAD participated in the Louisiana Integrated Treatment Services (LITS) Basic Orientation and Training course on treatment of individuals with co-occurring disorders. In the summer of 2006, the series of Advanced LITS trainings was completed. To date over 2,000 LGE and regional staff members have participated. These trained individuals have an impact on the ability of the direct service agencies to screen, assess, diagnose, treat and refer clients as needed. The summer of 2006 also marked the completion of the baseline fidelity assessments at each of the approximate 40 clinics throughout the state. This was followed up with a LITS State Summit that assisted with the development of local strategic plans for each of the 10 LGEs or Regions. OAD and OMH have also jointly purchased a learning management system that provides a continued mechanism to provide core curriculum on recovery, integrated care, co-occurring knowledge base in addition to a wide variety of other behavioral health issues.

The following is a list of relevant updates (2008 and 2009) to COSIG:

- In the 2009 legislative session, legislation was promulgated to integrate the Office of Mental Health with the Office for Addictive Disorders, creating an integrated Office of Behavioral Health. Although the details have not yet been developed, COSIG and the LITS implementation will continue to provide much of the structure and necessary guidance to support this significant department-wide initiative.
- Most recently, each of the 10 local Regions/Districts have undergone the follow-up DDCAT/DDCMHT assessments in order to measure the successful implementation of their LITS strategic plans. Results have also revealed areas of continuing need and future areas for co-occurring informed program development. Many of the local regions have continued to operate and maintain their LITS committees in order retain their focus on the continuing need to develop co-occurring informed care and to assist with future integration of OAD and OMH.
- Results of the follow-up DDCAT/ DDCMHT confirmed that overall the state showed forward movement in reaching the goal of having all clinics reach the Co-occurring Capable status. Over 50% of the programs reached the status of Co-occurring Capability. Several of the programs, especially those associated with locally governed districts, had adopted a fully integrated model and were well on the way to attaining the Co-occurring Enhanced status, which reaches beyond the Co-occurring Capable status.
- The joint relationship of OAD and OMH have continued and been strengthened under the initiative to integrated the two offices. Both OAD and OMH have continued to purchase

and share the learning management system that supports and develops the library system and resources for behavioral health needs and co-occurring care.

The following Table reflects information gathered from each of the Regions and LGEs regarding their programs related to Co-occurring disorders.

Total Numbers of Persons Served by Category and Region/ LGE (unduplicated) -- FY 2009

Region/ LGE	Screen	Assess	Diagnose	Treat	Refer
MHSD*	unavailable	unavailable	unavailable	unavailable	unavailable
CAHSD	11,123	3,086	1,185	639	789
III	4,815	4,815	1,522	1,522	1,522
IV	2,738	2,189	2,189	2,189	730
V	1,579	838	1,146	1,970	895
VI	1,227	1,227	461	789	37
VII	1,422	341	332	204	1,081
VIII	1,956	1,360	1,050	1,044	671
FPHSA	1,224	1,224	1,224	485	739
JPHSA	2,652	2,270	875	506	7
CLSH	231	231	231	231	231
ELMHS	379	379	379	1,365	0
NOAH*	unavailable	unavailable	unavailable	unavailable	unavailable
SELH	343	189	191	185	191

***data is incomplete/ unavailable**

MEDICAL & DENTAL HEALTH SERVICES
FY 2010 - ADULT PLAN

The Office of Mental Health attempts to offer a comprehensive array of medical, psychiatric and dental services to its clients. As noted in the *President's New Freedom Commission Report* Goal #1, mental health is essential to overall health, and as such a holistic approach to treating the individual is critical in a recovery and resiliency environment.

Acute inpatient units are provided primarily in Louisiana Health Sciences Center-Health Care Services Division (LSUHSC-HCSD) and LSU-Shreveport public general hospitals. The location of these units within or in the vicinity of general medical hospitals allows clients access to complete medical services. Intermediate care hospitals all have medical clinics and access to x-ray, laboratory and other medically needed services. Outpatient clients are encouraged to obtain primary care providers for their medical care. Those who do not have the resources to obtain a private provider are referred to the LSU system outpatient clinics. Adults who are clients of state operated mental health clinics or Medicaid funded Mental Health Rehabilitation services also benefit from a health screening with a referral, as needed.

Proper dental care is increasingly demonstrated to have an important role in both physical and mental health. Dental services are provided at intermediate care hospitals by staff or consulting dentists. Referrals for oral surgery may be made to the LSU operated oral surgery clinics. Some examples of low or no-cost dental services/resources available to OMH outpatient consumers include the Louisiana Donated Dental Services program, the David Raines Medical Clinic in Shreveport, the LSU School of Dentistry, the Lafayette free clinic, and the Louisiana Dental Association.

The LSU School of Dentistry (LSUSD) located in New Orleans sustained severe damage from flooding from Hurricane Katrina, and was forced to close, re-opening in the fall of 2007. In addition, various school-based dental clinics in MHSD that offered a full range of services also were destroyed but most have re-opened. An unexpected result of the closure of these facilities is that in order to continue to train dental and dental hygiene students, clinics opened in other parts of the state. Some of these clinics have remained open, although in smaller scale. The LSUSD campus serves primarily residents from the greater New Orleans area; however, LSUSD satellite clinics serve citizens in other areas of the state. In addition, Earl K. Long Hospital in Baton Rouge provides routine dental care.

Certain healthcare services are provided to pregnant women between the ages of 21 and 59, who are eligible for full Medicaid benefits. The LaMOMS program is an expansion of Medicaid coverage for pregnant women with an income up to 200 percent of the Federal Poverty Level. Through this program, pregnant women of working families, either married or single, have access to no-cost dental and healthcare coverage. Medicaid will pay for pregnancy-related services, delivery and care up to 60 days after the pregnancy ends including doctor visits, lab work/tests, prescription medicines and hospital care.

The LSU operated hospitals have always struggled to meet the needs of all citizens of Louisiana, but even more so since the storms of 2005. There is still debate about whether to rebuild the large teaching hospital in New Orleans, or if the citizens of New Orleans are better served by smaller clinics, with the teaching hospital moved to Baton Rouge. Medical homes, entities that would serve the primary care needs of Louisiana citizens and ensure proper referral to specialty services are a best practice that is beginning to take hold in the state.

Following the hurricanes, there was an exodus of healthcare providers from the state. This has resulted in long waiting periods for patients, who then often experience increased anxiety and higher levels of emotional and physical pain. Emergency Department waiting times have dramatically increased. In some regions, hospitals have begun offering some on-site medical services at the mental health clinics to patients who do not have transportation, and nursing staff is often available for general nursing consultation and referrals.

SUPPORT SERVICES
FY 2010 - ADULT PLAN

Support Services are broadly defined as services provided to consumers that enhance clinic-based services and aid in consumers' reintegration into society as a whole. Louisiana's public mental health system is grounded in the principle that persons with serious mental illness can and do recover. OMH has taken an approach that is consistent with Goal #2 of the *President's New Freedom Commission Report* emphasizing that mental health care is consumer and family driven. The Office of Consumer Affairs, created in 2004, was reorganized as the Office of Client, Youth and Family Affairs to develop more inclusive services for all those affected by mental health issues in Louisiana. The full-time director of the office is a self-identified consumer. Currently, the Office is focusing on issues of client choice and inclusion through initiatives that will enable choice, empowerment, and in certain instances, employment. With a focus on choice and inclusion this office continues to actively work towards the development of peer support programs, resource or drop-in-center development, coordination of a statewide advocacy network, and other initiatives that encourage consumer and family independence in all aspects of care. For example, in Fiscal Year 2009, Louisiana has continued to develop and implement a Peer Specialist Employment Program for consumers funded initially by Block Grant dollars. *Recovery Innovations, formally META Services,* was identified as the curriculum provider for the initial implementation phase. As a result of this training initiative, 70 mental health consumers have been certified as Peer Support Specialists, 35 of whom who are now employed across the statewide system of care. Additionally, the Office of Mental Health was awarded a grant to implement Wellness Recovery Action Planning (WRAP™), under the auspices of the Copeland Center for Wellness and Recovery. As a result, 69 consumers have been trained as Certified WRAP Facilitators and are now teaching classes that empower adult consumers to dictate their individual life roles and goals. These programs working in conjunction will aid in helping to further realize the vision of Goal #2 of the *President's New Freedom Commission Report* as described above. Peer Support Specialists are being used in the clinics; for instance, in Region 7 Peer Support Specialists are making 'engagement calls' to clients providing encouragement to attend aftercare appointments. The region reports that this approach has significantly decreased the numbers of failed first-time appointments for aftercare.

In the area of consumer empowerment, OMH has supported a variety of activities that aid consumers and their families. These supported activities include employment, housing, and education as described earlier. Activities also include the provision of financial and technical support to consumer and family organizations and their local chapters throughout the state. Self-help educational programs and support groups, funded by the Mental Health Block Grant are organized and run by consumers or family members on an ongoing basis. For example, BRIDGES, modeled after the Journey of Hope program for family members, is a consumer-run enterprise, providing education classes and support programs throughout the State of Louisiana.

In addition to the above activities, OMH hires parents of EBD children and adult consumers into State jobs as either consumer or family liaisons. These individuals assist other consumers and families to access services as well as provide general education and supportive activities such as accessing consumer and/or family care resources. Consumer resources include flexible funds that families and consumers can utilize to address barriers to care and recovery, in unique ways for that individual or family situation. The Louisiana Commission on the Employment of Mental Health Consumers was originally created in the 2004 legislative session in response to several state and federal initiatives including the *President's New Freedom Commission Report*. This employment group recently completed its tenure after formalizing methods to address employment opportunities for mental health consumers.

The Office of Mental Health partially or fully funds numerous Consumer Resource Centers (also called Drop-In Centers) that provide not only socialization opportunities, but activities designed to enhance both social and pre-vocational skills. Job Clubs that prepare consumers to seek employment by offering classes on job search, resume-writing, interview role-playing, etc. are a feature at many of the Resource Centers. Technical skills, such as computer literacy are also offered at Resource Centers. Many of these Consumer Resource Centers are consumer run or administered.

Consumer Resource Centers FY 2009

Region/ LGE	# of Consumer Resource Centers	Block Grant Funds	Total Funding Includes SGF& other sources	FY 07-08 #served unduplicated
MHSD	1 Center	0	$66,394	117
CAHSD	2 Centers	$115,495	$212,300	262
III	2 Centers	$299,974	$299,974	248
IV	2 Centers	$52,754	$102,754	246
V	1 Center	$29,700	$35,690	113
VI	3 Centers	$23,510	$123,735	519
VII	1 Center	$75,345	$260,400	161
VIII	3 Centers	$58,570	$171,657	171
FPHSA	1Center	0	$300,000	25
JPHSA	1 Center	0	$28,356	89
Totals:	**17 Programs**	**$655,348**	**$1,601,260**	**1,951**

All consumer focused services relate to Goal 2 of the *President's New Freedom Commission Report* calling for Mental Health care that is consumer and family driven. Renewed emphasis on consumer focused services is especially needed in light of the hurricanes and the economic downturn that has resulted in a limited capacity to support consumer-based services.

OTHER ACTIVITIES LEADING TO REDUCTION OF HOSPITALIZATION
FY 2010 - ADULT PLAN

Utilization of state hospital beds dropped significantly with the introduction of community-based Mental Health Rehabilitation (MHR) services and the development of brief stay psychiatric acute units within general public hospitals. Moreover, Louisiana and OMH have a network of services that provide alternatives to hospitalization for consumers and families in Louisiana through a broad array of community support services and consumer-run alternatives. Housing, employment, educational, rehabilitation, and support services programs, which take into account a recovery-based philosophy of care, all contribute to reductions in hospitalization.

OMH has begun an intermediate care hospital discharge initiative for FY 2010. The State of Louisiana has approximately 360 adults hospitalized in three state intermediate care hospitals. Not including the Olmstead project, the Office of Mental Health has set a goal of discharging 20% of patients from the hospital to a community setting of the patient's choice. Patients will be identified by discharge teams within each of the three hospitals. A technical assistance team from OMH Central Office will assist the three hospital discharge teams to make certain that appropriate community resources are available to ensure a seamless and successful discharge to the community.

In the event of crisis, hospitalization is a last resort, after community alternatives are tried and/or ruled out prior to inpatient hospitalization in a state inpatient facility. Implementation of the statewide Continuity of Care policy continues to enhance joint hospital-community collaboration with the goals of improved outcomes post-discharge including reduced recidivism. These tasks are inherent in Goal 5; Recommendation 4 of the *President's New Freedom Commission Report* which calls for states and communities to address the problems of acute and long term care; specifically addressing "assessing existing capacities and shortages coupled with delivering appropriate acute care services".

The Lafayette Jail Diversion Project – Target Capacity Expansion Grant is a $1.2 million three year grant funded by the Substance Abuse and Mental Health Services Administration. The grant is currently involved in its four year no cost extension phase. The Jail Diversion/ FREE (Fostering Recovery Education Empowerment) program functions essentially as a partial hospital treatment program providing a stable therapeutic environment for the assessment, diagnosis and treatment of major psychiatric illnesses. The program serves individuals with significant impairment resulting from a psychiatric, emotional or substance abuse disorder and is designed to have a positive impact on the client and his or her support system. To date, the Program has rendered services to 37 individuals working with their families and other natural support systems to steer each individual towards recovery. The Jail Diversion program has had successful linkages and collaborations with other agencies including ongoing partnerships with the Volunteers of America, Acadiana Recovery Center, Acadiana Outreach Center, Intensive Outpatient Programs at both Tyler Mental Health Clinic and at the Community Corrections Center, Office of Citizens with Developmental Disorders, Office of Addictive Disorders; and the primary partner, the Lafayette Parish Sheriff's Office. The goal has been to coordinate services to promote health and wellness, and to maximize independence and resources to support clients and members in their recovery. Jail diversion staff members also assist clients with provision of work uniforms, childcare services, and transportation to and from classes, work, home, and community resources. The program has provided personal laptops with wifi access to clients who are either in school, viably employed, or seeking work/education.

Another avenue of care that has succeeded in reducing hospitalization rates is the Mental Health Rehabilitation (MHR) program that allows greater flexibility of services; and the ability to cover additional services such as ACT and MST, which are consumer driven and recovery-focused. The previously discussed move of the MHR program into the DHH Medicaid Office should improve the availability of resources and flexibility to an even greater extent. Each OMH Region/ LGE also has specific initiatives aimed at reducing hospitalization and/or shortening hospital stays.

Many other programs previously discussed have either directly or indirectly had an impact on the utilization of inpatient services. For example the Louisiana Integrated Treatment Services (LITS) model for persons with Co-occurring Mental and Substance Disorders has resulted in increasing access to community services and reducing the need for hospitalization. The advent of using effective co-occurring capable services is intertwined with Goal 4; Recommendation 3 of the *President's New Freedom Commission Report* that calls for the linking of mental health and substance abuse treatment. The development of crisis services throughout the state is another example of programming that has resulted in decreased hospital utilization. The expanding use of telemedicine has also shown great promise and results.

As an adjunct to current services, Mental Health Emergency Room Extension (M-HERE) Units have been established in most Regions/ LGEs. M-HEREs provide a specifically designated program within hospital emergency departments to triage for behavioral health conditions. The services include medical clearance, behavioral health assessment and evaluation, and crisis treatment of a person in crisis to determine the level of service/resource need. The M-HERE provides the opportunity for rapid stabilization in a safe, quiet environment, increasing the person's ability to recognize and deal with the situations that may have initiated the crisis while working to increase and improve the network of community and natural supports. All patients receive a medical screening exam and appropriate medical evaluation.

M-HERE services include crisis stabilization and intervention; crisis risk assessment; nursing assessments; extended psychiatric observation and evaluation; behavioral health co-occurring evaluations; emergency medication; crisis support and counseling; information, liaison, advocacy consultation, and linkage to other crisis and community services. The M-HERE model provides the opportunity for close supervision, observation and interaction with patients. The treatment team staff can make involuntary commitment decisions secondary to the behavioral health need of the individual. The mix and frequency of services is based on each individual's crisis assessment and treatment needs.

The Mental Health Emergency Room Extension (M-HERE) includes:

- 24/7 on site nursing coverage
- Psychiatric physician on call availability
- Social Work coverage necessary to assessment and development of discharge plans
- Security services
- Close patient observation and supervision

Discharge from the M-HERE is to one of the following: (1) an acute inpatient unit, (2) a detox unit or co-occurring unit, (3) other community based crisis services (i.e., respite), or (4) other community resources if continued crisis services are not indicated. The goal is to have at least one M-HERE in each Region/ LGE. In addition, several Regions/ LGEs have at least one mobile crisis team, and adult and child crisis respite. The status of the MHERE initiative is as follows:

MHSD: University Hospital
CAHSD: Earl K Long Hospital (pending)
Region 3 Chabert Hospital
Region 4: University Medical Center
Region 5: Memorial Hospital (This service is not funded for FY 2010)
Region 6: Huey P. Long Hospital –contract ended– never opened and never staffed.
Region 7: none
Region 8: none
FPHSA: none
JPHSA: West Jefferson Hospital (pending)

Fiscal legislation passed in the 2009 legislative session allows OMH to close one of its state hospitals, New Orleans Adolescent Hospital (NOAH), and transfer the child/adolescent and adult acute beds to Southeast Louisiana Hospital (SELH); and with the savings in operational costs, will allow for the opening of two new community mental health clinics in locations convenient to consumers in the New Orleans area. The goal is to increase community outreach programs and outpatient clinics thereby reducing the need for inpatient services.

CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY – INCIDENCE & PREVALENCE ESTIMATES
LOUISIANA FY 2010 ADULT & CHILD/ YOUTH PLAN

Goal #6 of the *President's New Freedom Commission Report* states: "Technology Is Used to Access Mental Health Care and Information." In this regard, OMH continues to make great strides in upgrading information technology and in establishing electronic data systems to meet the growing and changing needs for information in support of service system management, program operations, quality improvement, and performance accountability.

OMH currently operates several statewide computerized information and performance measurement systems covering the major service delivery and administrative processes. These systems provide a wide array of client-level data: client characteristics, clinical assessments, type and amount of services provided, and outcome of services. OMH also performs centralized electronic billing for Medicaid and Medicare for all CMHCs statewide. OMH has been progressively moving towards one, integrated, web-based system to serve the reporting and electronic health record needs of the agency, sequentially retiring legacy systems and modernizing features at each step along the way.

OMH-IIS (Office of Mental Health – Integrated Information System) is the state-of-the-art web-based information system development, operating in an integrated fashion over the DHH wide-area network (WAN) on a central SQL server. The current system has undergone several phases of a series of planned, sequenced enhancements, documented in previous Block Grant plans. At each step of the way the corresponding functions in ARAMIS (Accounts Receivable and Management Information System), which is the legacy LAN-based information system that served these functions previously, have been "retired." This past fiscal year, the OMH-IIS centralized Provider Registry was upgraded and the following new modules were added to OMH-IIS: 1) Assessment; 2) Admission/ Discharge/ Transfer; and 3) Service Ticket/ Progress Note. The Service Ticket/ Progress Note, the most recently implemented module, moves OMH-IIS ever closer to establishing the foundation for an electronic behavioral health record. Staff no longer need use paper service tickets or progress notes. The plan for further development of OMH-IIS is to sequentially replace the remaining separate, non-integrated LAN-based legacy systems now operating statewide by extending the functionality of the expanding OMH-IIS system. The remaining major ARAMIS function to be replaced is Accounts Receivables, scheduled to be migrated into OMH-IIS this Fall. In addition, OMH plans to add centralized appointment scheduling integrated into the system; addition of registry of contract programs to enable determining the total number of unique persons served across the system of care, and addition of the service recording and Medicaid billing for the Early Childhood Supports and Services program. Additional modules planned include: Provider credentialing & privileging (in conjunction with the current central provider registration); Expanded assessments and quality management functions, including capacity for contemporary performance & outcome measures and a continuity-of-care record; Tracking clients enrolled in evidenced-based treatments; and a central program registration system. While the current OMH-IIS employs current information technologies, rapidly changing technology and the development of standards requires its updating to serve as the core for the new system development.

In October 2008, OMH initiated the use of the electronic Level of Care Utilization System (LOCUS) as foundational component of the Cornerstone Utilization Management program. LOCUS is a well-established clinical rating instrument that will be used to determine target population eligibility and intensity of need over the course of treatment. Access to this instrument has been integrated into the OMH-IIS assessment section and data submitted becomes part of the OMH data warehouse allowing LOCUS data to be linked to all existing clinical information within the warehouse. OMH also procured CA-LOCUS and will be integrating it into OMH-IIS this fiscal year.

As part of the continuing implementation of a Utilization Management/Accountable Care program for OMH operations, this year OMH procured use of the Service Process Quality Management (SPQM) system, a proprietary web-based analytical system developed by MTM Services, Inc., which utilizes standardized data uploaded from the OMH data warehouse and displays it through dashboards and cross-tables for data-based decision making and program performance improvement by state managers (OMH regions and LGEs). Staff members participate in monthly SPQM webinars conducted by David Lloyd, Accountable Care expert, for purposes of advancing their competencies in data-based decision making.

OMH has procured and will soon implement the Telesage Outcome Measurement (TOMS) system statewide, funded under the Data Infrastructure Grant. This system utilizes standardized client self-report outcome surveys and provides provider staff the means to monitor client treatment outcomes at repeated intervals over the course of treatment. This electronic outcome measurement system will transfer data into the OMH data warehouse where it will be combined with the existing clinical data allowing for more complex analysis of client outcomes from treatment.

OMH continues to operate the several legacy systems until these are systematically replaced by OMH-IIS, but continue to provide needed performance data. These systems are largely custom-built, LAN-based, and compliant with national data standards (e.g., Mental Health Statistics Improvement Program - MHSIP). These legacy systems include:

PIP/PIF/ORYX. The Patient Information Program, implemented in 1992, operates in each of the five state hospitals and three regional acute units. It provides a comprehensive array of data on inpatients served. A financial module (PIF), implemented in 1994, supports billing, and the ORYX module, implemented in 1999, supports performance reporting for JCAHO accreditation. PIP is a DOS-based system. This system is in line after ARAMIS to be rolled into OMH-IIS.

MHR/MHS & UTOPiA. The Mental Health Rehabilitation/Mental Health Services system, implemented in 1995, supports client, assessment, and service data collection and reporting for mental health rehabilitation provider agencies and contract mental health service program providers (mainly case management). The Utilization, Tracking, Oversight, and Prior Authorization system provides for prior authorization of services and utilization and outcomes management at the state and area levels. MHR/MHS & UTOPiA run in Visual Fox Pro. There is recent interest in evaluating the possibility of incorporating the functions of MHR/MHS & UTOPiA into OMHIIS during Phase 5 enhancements. However, recent events may make this unnecessary. As of July 1, 2009, the Mental Health Rehabilitation Services Unit will be completely transferred to be within the Medicaid Office in DHH. As such, data for MHR/MHS may be maintained within the Medicaid Integrated Data System. It has not yet been decided how the coordination of data between Medicaid and OMH will take place.

HCS MEDICS. OMH operates the proprietary Health Care Systems (HCS) Medics pharmacy software in each of the seven regional community pharmacies and each of the five state hospitals. This software automates prescription processing and management reporting of utilization of pharmaceuticals. It interfaces with PIP in the hospitals to capture patient admission data.

OTHER SYSTEMS. In addition to the above listed OMH data systems, there exist program specific data systems that are supported by OMH. These include the CRIS data system for the Child and Adolescent Response Team (CART), the ECSS-MIS supporting the Early Childhood Supports and Services (ECSS), and RiteTrack, a proprietary information system supporting the Louisiana Youth Enhancement Services (LA-YES). In each case, these specialized service programs have unique database needs that have been addressed by either building a suitable database in-house or in the case of LA-YES, purchasing a compatible commercial data management system. In each of these cases, efforts have been made to make sure that whatever system is being used, its structure and data formats are compatible with OMH-IIS such that key clinical information can be uploaded to OMH-IIS which is the primary repository of this information for OMH.

According to the *2008 Annual Estimates of the Resident Population 7/1/2008 State Characteristics, Population Estimates Division, U.S. Census Bureau (released May 14, 2009)*, the total number of adults in Louisiana is 3,302,823. Of these, according to national benchmarks, 2.6% are expected to have Serious Mental Illness (SMI). That translates into a total of 85,873 adults with serious mental illness (SMI) in Louisiana based on national prevalence rates. According to the same census report, the total number of children and youth in Louisiana is 1,107,973. Of these, according to national benchmarks, 9% are expected to have an Emotional or Behavioral Disorder (EBD). That translates into a total of 99,718 children and youth with an EBD in Louisiana based on national prevalence rates. Of this number, it is expected that between 20,000 and 40,000 should be served by the public mental health system including the Medicaid Agency mental health rehabilitation program.

Statistics show that 38,544 adults with SMI received outpatient services under the OMH umbrella in FY 2009 through both Community Mental Health Clinics and the Mental Health Rehabilitation (MHR) program. The Mental Health Rehab (MHR) program served 2,182 adults in FY 2009. Of the total number of adults served, both with and without SMI (48,359), 80% met the definition of Seriously Mentally Ill (SMI). Statistics show that 12,680 children and youth with EBD received outpatient services under the OMH umbrella in FY 2009 through both Community Mental Health Clinics and the Mental Health Rehabilitation (MHR) program. The MHR program served 5,205 children and youth. Of the total number of children and youth served (15,141), 84% met the definition of EBD.

As has been true since the hurricanes, many individuals who were in acute crises were seen in CMHCs as a result of the aftermath of the hurricanes, and did not meet the more strict criteria of SMI or EBD. Strict comparisons between years are not feasible since some years Jefferson Parish Human Services Authority (JPHSA) data is included, and other years it is not; due to changes in the data systems.

As the term is used in Louisiana, SMI is a national designation that includes only those individuals suffering from the most severe forms of mental illness. EBD is a national designation for children/ youth that includes only those individuals suffering from the most severe forms of mental illness. Those who have any type of mental illness would increase the population figures, but not the

numbers of individuals served, since Louisiana's outpatient mental health facilities are designated to serve only those adults with SMI and children and youth with EBD. Therefore, individuals with SMI/ EBD are considered to be the target population for these programs. These numbers reflect an unduplicated count within regions and LGEs.

Louisiana OMH Community Mental Health Clinics
ADULTS – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/LGEs FY0809

Regions / LGEs	Adults with SMI Served (persons served)	Total Adults Served	% SMI
MHSD	6,539	9,899	66%
CAHSD	5,476	6,490	84%
REG 03	5,629	6,378	88%
REG 04	4,152	5,061	82%
REG 05	1,235	1,454	85%
REG 06	1,882	2,846	66%
REG 07	2,137	2,315	92%
REG 08	2,579	2,694	96%
FPHSA	3,267	3,521	93%
JPHSA	3,466	5,519	63%
MHR	2,182	2,182	100%
TOTAL	38,544	48,359	80%

Data Source: ARAMIS, JPHSA, MHR

Louisiana OMH Community Mental Health Clinics
CHILD/YOUTH – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/LGEs FY0809

Regions / LGEs	Children/Youth with EBD Served (persons served)	Total Children/Youth Served	% SMI
REG 01 CHILD/YOUTH CLINICS	737	956	77%
MHSD	21	63	33%
CAHSD	2272	2631	86%
REG 03	261	294	89%
REG 04	706	868	81%
REG 05	220	248	89%
REG 06	323	636	51%
REG 07	774	814	95%
REG 08	269	285	94%
FPHSA	863	959	90%
JPHSA	1029	2182	47%
MHR	5205	5205	100%
TOTAL	12680	15141	84%

Data Source: ARAMIS, JPHSA, and MHR

Data Definitions & Methodology

SMI and EBD Definitions: OMH population definitions follow the national definition. However, Louisiana uses the designation SMI for what is more usually referred to as SPMI. SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness.

Estimation Methodology: OMH uses the CMHS estimation methodology, applying the national prevalence rates for SMI (2.6%) and EBD (9%) directly to current general population counts to arrive at the estimated prevalence of targeted persons to be served. This method has been used since the revised rates were published in 1996.

Admissions: Number of clients that have been admitted during the time period.

Caseload/ Census: Active clients on a specified date. Caseload assumes that when a case is no longer active, it is closed.

Discharges: Number of clients that have been discharged during the time period.

Persons Served: The number of clients that had an active case for at least one day during the time period. Persons served is the combination of the number of active clients on the first day of the time period along with the number of admissions during the time period.

Persons Receiving Services: (CMHC only) The number of clients who received at least one service at a CMHC during the time period. This includes CONTACTS who are not admitted.

Unduplicated: Counts individual clients only once even if they appear multiple times during the time period.

Duplicated: Duplicated counts episodes of care, where clients are counted multiple times if they appear in the same time period multiple times.

Note: The duplicated number must always equal or be larger than the unduplicated number.

Adult Target Population

An adult who has a serious and persistent mental illness meets the following criteria for *Age*, *Diagnosis, Disability*, and *Duration.*

Age: 18 years of age or older

Diagnosis: Severe non-organic mental illnesses including, but not limited to schizophrenia, schizo-affective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships and work or school.

Disability: Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:

1. Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
2. Employed in a sheltered setting.

3. Requires public financial assistance for out-of-hospital maintenance (i.e., SSI) and/or is unable to procure such without help; does not apply to regular retirement benefits.
4. Severely lacks social support systems in the natural environment (i.e., no close friends or group affiliations, lives alone, or is highly transient).
5. Requires assistance in basic life skills (i.e., must be reminded to take medicine, must have transportation arranged for him/her, needs assistance in household management tasks).
6. Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

Duration: Must meet at least one of the following indicators of duration:

1. Psychiatric hospitalizations of at least six months in the last five years (cumulative total).
2. Two or more hospitalizations for mental disorders in the last 12 month period.
3. A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.
4. A previous psychiatric evaluation or psychiatric documentation of treatment indicating a history of severe psychiatric disability of at least six months duration.

OMH is in the process of revising and refining the definition of the Target Population to include such things as clients' functional status.

Child/Youth Target Population

A child or youth who has an emotional/behavioral disorder meets the following criteria for Age, Diagnosis, Disability, and Duration as agreed upon by all Louisiana child serving agencies.

Note: For purposes of medical eligibility for Medicaid services, the child/youth must meet the criteria for diagnosis as contained in Item 4 of the Diagnosis Section below; Age and Disability must be met as described below; Duration must be met as follows: Impairment or patterns of inappropriate behavior which have/has persisted for at least three months and will persist for at least a year.

Age: Under age 18

Diagnosis: Must meet one of the following:

1. Exhibit seriously impaired contact with reality, and severely impaired social, academic, and self-care functioning, whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; or,
2. Manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; or
3. Experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; or
4. Have a DSM-IV (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive), or severe conduct disorder. This category does not include children/youth who are

socially maladjusted unless it is determined that they also meet the criteria for emotional/behavior disorder.

Disability: There is evidence of severe, disruptive and/or incapacitating functional limitations of behavior characterized by at least two of the following:

1. Inability to routinely exhibit appropriate behavior under normal circumstances;
2. Tendency to develop physical symptoms or fears associated with personal or school problems;
3. Inability to learn or work that cannot be explained by intellectual, sensory, or health factors;
4. Inability to build or maintain satisfactory interpersonal relationships with peers and adults;
5. A general pervasive mood of unhappiness or depression;
6. Conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then children determined to be "conduct disordered" are eligible.

Duration: Must meet at least one of the following:

1. The impairment or pattern of inappropriate behavior(s) has persisted for at least one year;
2. There is substantial risk that the impairment or pattern or inappropriate behavior(s) will persist for an extended period;
3. There is a pattern of inappropriate behaviors that are severe and of short duration.

OMH is in the process of revising and refining the definition of Target Population to include such things as clients' functional status.

Louisiana Population and Prevalence Estimates

Over the last several years, Louisiana population figures have been extremely difficult to estimate based on the mass evacuations and relocations following Hurricanes Katrina and Rita in 2005, and Hurricanes Gustav and Ike in 2008. Overall, the population of the State continues to be slightly less than prior to the 2005 storms. Initially, people evacuated from the state due to loss of homes and infrastructure. Since that time, some citizens have left the state due to dissatisfaction with the rebuilding efforts and other problems resulting from the 2005 and the 2008 storms. Population figures continue to be in flux, making estimates difficult and somewhat unreliable. Within the state, the parishes hardest hit by the hurricanes have generally experienced an overall decrease in population, while some other parishes have experienced an increase in population.

The *2005 American Community Survey Gulf Coast Area Data Profiles: September through December, 2005 (revised July 19, 2006)* was released in an attempt to measure the population post – hurricanes, and at that time there had been a dramatic loss in population. There were estimated to be 3,688,996 individuals in Louisiana (2,742,070 adults, and 945,926 children). The Population Division of the US Census Bureau recently published the *Annual Estimates of the Resident Population by Single-Year 7/1/2008 - State Characteristics Population Estimates (Released May 14, 2009)*. The more recent data is listed in the tables below. A comparison of these sets of figures shows that the trend is for Louisiana's population to once again increase, although not yet up to pre-2005 levels. The 2008 numbers indicate that there were 4,410,796 persons living in the state, down from the 2000 Census that reported that there were a total of 4,468,978 persons living in Louisiana.

Estimates of the prevalence of mental illness within the state, parishes, regions, and LGEs for Adults and Children/ youth are shown in the following tables. Caution should be used when utilizing these figures, as there is much population movement and the figures may not be entirely reliable.

PREVALENCE ESTIMATES*

July 1, 2008 - (Released May 14, 2009)

	Child/ Youth 9%		Adult 2.6%		Total	
Louisiana	Pop Count	Prev Count	Pop Count	Prev Count	Pop Count	Prev Count
State-wide	1,107,973	99,718	3,302,823	85,873	4,410,796	185,591

* CO-EST2008-alldata: Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2008 County Population Estimates Source: Population Division, US Census Bureau. Release Date: May 14, 2009. http://www.census.gov/popest/datasets.html.

Prev. Count = Estimated Prevalence Count (2.6% Adults*, 9%Children**) Adult =18 Years of Age and Older
Child/Youth =17 Years of Age and Younger
* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.
** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

Please note: Louisiana uses the designation SMI for what is more usually referred to as SPMI.
SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness. Those who have all types of mental illness would increase the population figures, but would not increase the numbers of individuals served since Louisiana's facilities are designated to serve those with SMI (SPMI).

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by Region/District and Parish (July 1, 2008 Pop Est)*

REGION/ DISTRICT	PARISH	CHILD/ YOUTH (Under 18) POPULATION ESTIMATE	CHILD/ YOUTH (Under 18) PREVALENCE ESTIMATE	ADULT (Age 18 and Above) POPULATION ESTIMATE	ADULT (Age 18 and Above) PREVALENCE ESTIMATE	TOTAL POPULATION ESTIMATE JULY 1, 2008	TOTAL PREVALENCE ESTIMATE
1- METROPOLITAN HUMAN SERVICE DISTRICT	Orleans	64,171	5,775	247,682	6,440	311,853	12,215
	Plaquemines	5,594	503	15,682	408	21,276	911
	St. Bernard	7,613	685	30,109	783	37,722	1,468
Total for 1- MSHD		77,378	6,964	293,473	7,630	370,851	14,594
2- CAPITAL AREA HUMAN SERVICE DISTRICT	Ascension	29,423	2,648	72,366	1,882	101,789	4,530
	East Baton Rouge	106,487	9,584	321,873	8,369	428,360	17,953
	East Feliciana	4,716	424	16,158	420	20,874	845
	Iberville	7,716	694	24,829	646	32,545	1,340
	Pointe Coupee	5,383	484	17,018	442	22,401	927
	West Baton Rouge	5,732	516	16,821	437	22,553	953
	West Feliciana	2,362	213	12,641	329	15,003	541
Total for 2 - CAHSD		161,819	14,564	481,706	12,524	643,525	27,088
Region 3	Assumption	5,489	494	17,392	452	22,881	946
	Lafourche	22,558	2,030	70,014	1,820	92,572	3,851
	St. Charles	13,494	1,214	38,053	989	51,547	2,204
	St. James	5,431	489	15,800	411	21,231	900
	St. John the Baptist	13,344	1,201	33,650	875	46,994	2,076
	St. Mary	13,433	1,209	37,650	979	51,083	2,188
	Terrebonne	29,135	2,622	79,441	2,065	108,576	4,688
Total for Region 3		102,884	9,260	292,000	7,592	394,884	16,852
Region 4	Acadia	16,505	1,485	43,565	1,133	60,070	2,618
	Evangeline	9,633	867	25,991	676	35,624	1,543
	Iberia	20,392	1,835	54,705	1,422	75,097	3,258
	Lafayette	53,354	4,802	153,622	3,994	206,976	8,796
	St. Landry	24,801	2,232	67,372	1,752	92,173	3,984
	St. Martin	13,687	1,232	38,410	999	52,097	2,230
	Vermilion	14,371	1,293	41,725	1,085	56,096	2,378
Total for Region 4		152,743	13,747	425,390	11,060	578,133	24,807

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by Region/District and Parish (July 1, 2008 Pop Est)*

REGION/ DISTRICT	PARISH	CHILD/ YOUTH (Under 18) POPULATION ESTIMATE	CHILD/ YOUTH (Under 18) PREVALENCE ESTIMATE	ADULT (Age 18 and Above) POPULATION ESTIMATE	ADULT (Age 18 and Above) PREVALENCE ESTIMATE	TOTAL POPULATION ESTIMATE JULY 1, 2008	TOTAL PREVALENCE ESTIMATE
Region 5	Allen	5940	535	19695	512	25635	1,047
	Beauregard	8,933	804	26,045	677	34,978	1,481
	Calcasieu	47,702	4,293	137,916	3,586	185,618	7,879
	Cameron	1,497	135	5,741	149	7,238	284
	Jefferson Davis	8,304	747	22,959	597	31,263	1,344
Total for Region 5		72,376	6,514	212,356	5,521	284,732	12,035
Region 6	Avoyelles	10,735	966	31,625	822	42,360	1,788
	Catahoula	2,456	221	8,066	210	10,522	431
	Concordia	4,770	429	14,294	372	19,064	801
	Grant	5,135	462	14,839	386	19,974	848
	La Salle	3,391	305	10,671	277	14,062	583
	Rapides	34,206	3,079	98,925	2,572	133,131	5,651
	Vernon	14,390	1,295	31,249	812	45,639	2,108
	Winn	3,380	304	12,028	313	15,408	617
Total for Region 6		78,463	7,062	221,697	5,764	300,160	12,826
Region 7	Bienville	3456	311	11272	293	14728	604
	Bossier	29,996	2,700	80,254	2,087	110,250	4,786
	Caddo	63,910	5,752	188,985	4,914	252,895	10,666
	Claiborne	3,373	304	12,769	332	16,142	636
	De Soto	6,698	603	19,690	512	26,388	1,115
	Natchitoches	9,811	883	29,765	774	39,576	1,657
	Red River	2,477	223	6,641	173	9,118	396
	Sabine	5,900	531	17,788	462	23,688	993
	Webster	9,430	849	31,324	814	40,754	1,663
Total for Region 7		135,051	12,155	398,488	10,361	533,539	22,515

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by Region/District and Parish (July 1, 2008 Pop Est)*

REGION/ DISTRICT	PARISH	CHILD/ YOUTH (Under 18) POPULATION ESTIMATE	CHILD/ YOUTH (Under 18) PREVALENCE ESTIMATE	ADULT (Age 18 and Above) POPULATION ESTIMATE	ADULT (Age 18 and Above) PREVALENCE ESTIMATE	TOTAL POPULATION ESTIMATE JULY 1, 2008	TOTAL PREVALENCE ESTIMATE
Region 8	Caldwell	2,326	209	8,027	209	10,353	418
	East Carroll	2,178	196	5,988	156	8,166	352
	Franklin	5,011	451	14,995	390	20,006	841
	Jackson	3,504	315	11,687	304	15,191	619
	Lincoln	9,084	818	33,477	870	42,561	1,688
	Madison	3,371	303	8,419	219	11,790	522
	Morehouse	6,968	627	21,634	562	28,602	1,190
	Ouachita	39,586	3,563	110,465	2,872	150,051	6,435
	Richland	5,213	469	15,288	397	20,501	867
	Tensas	1,285	116	4,409	115	5,694	230
	Union	5,492	494	17,200	447	22,692	941
	West Carroll	2,565	231	8,930	232	11,495	463
Total for Region 8		86,583	7,792	260,519	6,773	347,102	14,566
9-FLORIDA PARISHES HUMAN SERVICES AUTHORITY	Livingston	32,932	2,964	87,324	2,270	120,256	5,234
	St. Helena	2,523	227	8,023	209	10,546	436
	St.Tammany	59,124	5,321	169,332	4,403	228,456	9,724
	Tangipahoa	30,920	2,783	86,081	2,238	117,001	5,021
	Washington	11,727	1,055	33,703	876	45,430	1,932
Total for 9-FPHSA		137,226	12,350	384,463	9,996	521,689	22,346
10-JEFFERSON PARISH HUMAN SERVICES AUTHORITY	Jefferson	103,450	9,311	332,731	8,651	436,181	17,962
Total for 10-JPHSA		103,450	9,311	332,731	8,651	436,181	17,962
GRAND TOTAL		1,107,973	99,718	3,302,823	85,873	4,410,796	185,591

CO-EST2008-alldata: Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2008 County Population Estimates Source: Population Division, US Census Bureau. Release Date: May 14, 2009. http://www.census.gov/popest/datasets.html.
Prev. Count = Estimated Prevalence Count (2.6% Adults*, 9% Children/ Youth**)

**Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. US Department of Health and Human Services pp. 59-70.*

***Source for Child prevalence estimate: Friedman, R.M., et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. US Department of Health and Human Services pp. 71-89.*

Please Note: Louisiana uses the designation SMI for what is more usually referred to as SPMI. SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness. Those who have all types of mental illness would increase the population figures, but would not increase the numbers of individuals served since Louisiana's facilities are designated to serve those with SMI (SPMI).

POPULATION STATISTICS
FY 2010 - ADULT & C/ Y PLAN

POPULATION BY AGE

State's Population By Age Range*		
Age Range	**Number of Persons**	**Percentage of State's Population**
0-17	1,107,973	25%
18+	3,302,823	75%
TOTAL	4,410,796	100%

*Based on Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2008 County Population Estimates Source: Population Division, US Census Bureau. Release Date: May 14, 2009.

LOUISIANA OMH COMMUNITY MENTAL HEALTH CLINICS DATA UNDUPLICATED COUNT OF PERSONS RECEIVING SERVICES FROM JULY 1, 2008 TO JUNE 30, 2009 (ARAMIS & JPHSA)

	UNDUPLICATED PERSONS RECEIVING SERVICES		
	CHILD (0-17)	**ADULT (18+)**	**TOTAL**
REGION/LGE			
REGION 1 CHILD/YOUTH CLINICS	784	.	784
MHSD	27	7,396	7,423
CAHSD	2,246	6,196	8,442
REGION 3	377	6,201	6,578
REGION 4	674	4,747	5,421
REGION 5	274	1,627	1,901
REGION 6	684	2,725	3,409
REGION 7	915	2,474	3,389
REGION 8	397	3,434	3,831
FPHSA	1,485	5,638	7,123
JPHSA	2,496	4,974	7,470
TOTAL	10,359	45,412	55,771

Data Source: ARAMIS and JPHSA Run Date: 8/25/09

Persons receiving services is the number of clients who received at least one service at CMHC during the time period. This includes CONTACTS who are not admitted.

*CAHSD data includes School-based Services.

INPATIENT & OUTPATIENT CASELOAD ON JUNE 30, 2009 WITH SMI/EBD; PERCENTAGE OF SMI/EBD

CASELOAD ON June 30, 2009 CMHC/PIP	ADULT: SMI CHILD: SED		OTHER		
	COUNT	Percent SMI/ EBD	COUNT	Percent Other	TOTAL
Age 0-17	4,317	69	1,903	31	6,220
Age 18+	29,189	77	8,540	23	37,729
.	8	36	14	64	22
TOTAL	33,512	76	10,455	24	43,967

Data from CMHC ARAMIS, PIP and JPHSA

NOTE: Prior to the FY 2009 MHBG, totals have not included data from Jefferson Parish Human Service Authority (not available)

CMHC ADULT CASELOAD SIZE ON LAST DAY OF FY2008 & FY2009

	FY07-08			FY08-09		
	Age 18-64	Age 65+	TOTAL 18+	Age 18-64	Age 65+	TOTAL 18+
REGION						
CAHSD	4642	283	4925	4708	284	4992
SCLMHA	4615	286	4901	5122	284	5406
Region 4	3506	165	3671	3769	176	3945
Region 5	962	36	998	846	29	875
Region 6	1922	83	2005	2110	93	2203
Region 7	1578	79	1657	1535	48	1583
Region 8	1793	89	1882	1934	90	2024
FPHSA	2470	135	2605	2455	134	2589
JPHSA	2620	95	2715	4508	128	4636
MHSD	7177	307	7484	9101	378	9479
TOTAL	31285	1558	32843	36088	1644	37732

Data from CMHC ARAMIS and JPHSA

CMHC CHILD/ YOUTH CASELOAD SIZE ON LAST DAY OF FY2008 & FY2009

	FY07-08			FY08-09		
	Age 0-11	Age 12-17	TOTAL 0-17	Age 0-11	Age 12-17	TOTAL 0-17
REGION						
Region 1 (Child/Youth Clinics)	255	247	502	321	299	620
CAHSD	700	833	1533	859	876	1735
SCLMHA	42	90	132	65	150	215
Region 4	180	274	454	237	272	509
Region 5	37	81	118	56	72	128
Region 6	138	172	310	154	213	367
Region 7	178	232	410	146	216	362
Region 8	62	121	183	69	99	168
FPHSA	279	263	542	294	288	582
JPHSA	388	494	882	601	893	1494
MHSD	4	8	12	4	8	12
TOTAL	2263	2815	5078	2806	3386	6192

Data from CMHC ARAMIS and JPHSA (tc 8/24/09)

CASELOAD SERVED BY OMH COMPARED TO PREVALENCE ESTIMATES AND CENSUS DATA FY 2010 - ADULT & CHILD/ YOUTH PLAN

Age Range	LA Population Estimated*	National Prevalence Rate	Est. Number of persons in LA Population with SMI/EBD
Child/ Youth* 0-17	1,107,973	9%	1,107,973 X .09= **99,718**
Adult 18+**	3,302,823	2.6%	3,302,823 X .026= **85,873**
Total	4,410,796	-----	**185,591**

*Based on Annual Resident Population Estimates: Annual State Population Estimates by Demographic. File: 7/1/2008 County Population Estimates Source: Population Division, US Census Bureau. Release Date: May 14, 2009.

Age Range	Est. Number of persons in LA population with SMI/EBD	Number of Persons with SMI/EBD in OMH Caseload*	Louisiana Percent of Prevalence Served*
Child/ Youth 0-17	**99,718**	4,317	4,317 / 99,718= **4.3 %**
Adult 18+	**85,873**	29,189	29,189 / 85,873= **33.9 %**
Total	**185,591**	33,512	33,512 / 185,591= **18.1 %**

PLEASE NOTE: These figures do not include persons seen in the offices of private practitioners. These figures do not include persons seen in the Mental Health Rehab programs, which served 2,182 adults and 5,205 children and youth.

Prev. Count = Estimated Prevalence Count (2.6% Adults*, 9%Children**) Adult =18 Years of Age and Older
Child/Youth =17 Years of Age and Younger
* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.
** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

Please note: Louisiana uses the designation SMI for what is more usually referred to as SPMI.
SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness. Those who have all types of mental illness would increase the population figures, but would not increase the numbers of individuals served since Louisiana's facilities are designated to serve those with SMI (SPMI).

CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY – QUANTITATIVE TARGETS
LOUISIANA FY 2010 ADULT & CHILD/ YOUTH PLAN

Setting quantitative goals to be achieved for the numbers of adults who are seriously mentally ill and children and youth who are emotionally or behaviorally disordered, who are served in the public mental health system is a key requirement of the mental health block grant law. These numbers also relate directly to the *President's New Freedom Commission Report,* Goal # 4, Early Mental Health Screening, Assessment, & Referral to Services Are Common Practice.

The Office of Mental Health has set a goal to increase access to mental health services to persons with SMI/ EBD. Quantitatively, this means increasing the numbers of new admissions of persons with SMI/ EBD. Quantitative targets relate to the National Outcome Measure (NOMS) Performance Indicator "Increased Access to Services". Louisiana reported this indicator in the past as the percentage of prevalence of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. The measure of the NOMS is now being requested to be reported as simply the number of persons who have a mental illness and receive services.

The figures below should be interpreted with caution due to fluctuations and inaccuracies in population figures following the hurricanes of 2005. After Hurricane Katrina/ Rita the population of the state decreased, and efforts to reach the SMI population intensified. Through these efforts it appears that the percent of prevalence in years after Hurricane Katrina/ Rita increased somewhat. Perhaps more than any other criteria, the Indicators for Criterion #2 continue to be the most difficult to predict or plan for. Post- hurricanes, it is difficult to determine a baseline upon which to estimate the outcomes for this Criterion.

ADULT POPULATION

Previously, the measure was reported as a percentage:

- Numerator: Estimated unduplicated count of adults who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting.
- Denominator: Estimated prevalence of adults in Louisiana with serious mental illness during a twelve month period.

These figures for the Adult population for each of the preceding years were:

FY 2004 23,954/ 84,475 X 100 = 28.36%
FY 2005 25,297/ 84,475 X 100 = 29.95%
FY 2006 24,667/ 71,294 X 100 = 34.6%
FY 2007 25,604/ 71,294 X 100 = 35.9%
FY 2008 27,619/ 83,555 X 100 = 33.05%
FY 2009 29,189 / 85,873 X 100 = 33.9%

CHILD/ YOUTH POPULATION

Previously, the measure was reported as a percentage:

- Numerator: Estimated unduplicated count of children / youth who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting.
- Denominator: Estimated prevalence of children / youth in Louisiana with serious mental illness during a twelve month period.

These figures for the C/Y population for each of the preceding years were:

FY 2004 3,571/ 109,975 X 100 = 3.25%
FY 2005 3,765/ 109,975 X 100 = 3.43%
FY 2006 3,552/ 85,223 X 100 = 4.17%
FY 2007 3,818/ 85,223 X 100 = 4.5%
FY 2008 4,286/ 97,160 X 100 = 4.4%
FY 2009 4,317 / 99,718 X 100 = 4.3 %

- For specific information on the quantitative targets that are now reported only as the unduplicated count of adults (i.e., the Numerator only) who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting see the Performance Indicator section of this document.

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS – OUTREACH TO HOMELESS
LOUISIANA FY 2010 - ADULT PLAN

The face of homelessness changed in Louisiana due to the aftermath of Hurricanes Katrina and Rita in 2005, and Gustav and Ike in 2008. Many individuals and families experienced homelessness for the first time as a result of these storms. In a recent article printed in Baton Rouge's daily paper, *The Advocate*, about 3,000 families who were left homeless after the hurricanes of 2005 are again looking for housing as their federal housing assistance comes to an end. According to FEMA, there are approximately 3,334 trailers or mobile homes still in use by hurricane evacuees. The Louisiana Family Recovery Corps, a Baton Rouge-based nonprofit created after the hurricanes to assist families was reported to be assisting another 14,600 families who continue to be in the federal Disaster Housing Assistance program which is to end on August 31, 2009.

There is no doubt that hurricanes continue to have a tremendous impact on housing and homelessness in the state. This is particularly significant since the areas of the state that were the most directly hit by the storms of 2005 and 2008 were the areas that have traditionally had the greatest population, and therefore the highest rates of homelessness, as well as the highest numbers of people with mental illness. State housing recovery efforts for affordable housing continue amidst a multiplicity of barriers including changes in development costs at all levels and local resistance to affordable housing development. Programs that aid persons with mental illness who are homeless relate to eliminating the disparities in mental health services, Goal #3 of the *President's New Freedom Commission Report*.

The Louisiana Interagency Council on Homelessness that participated in the United States Interagency Council was not reauthorized by the current state administration. The State Department of Social Services is responsible for the state's Emergency Shelter Grant funds. As part of the Department's grantee responsibilities, the department surveys shelters and compiles an annual report on the unduplicated numbers served in shelters across the state. The DSS Shelter Survey is a twelve month unduplicated count of persons using the state's shelter system. It also includes a point in time count that examines the subpopulations represented in the shelter count and the reasons for homelessness. The shelter information is current through 2008. There are 153 shelters in the DSS database. In 2008, the number of shelters reporting was 119 or 78% of the 153. The data revealed that the yearly total of homeless persons served was 32,112.

Experience suggests that persons with mental illness are underserved in the general shelter population and, therefore, there may be significant numbers of *unsheltered* homeless who have a mental illness. It is also likely that there are a number of persons *sheltered* who are undisclosed as having a mental illness and, therefore, their mental illness is undetected and not included in the count. In addition, prevalence of substance abuse among adults with serious mental illness is between 50-70%. Taking those factors into consideration, some sources use the higher percentage of 30% in calculating homelessness for persons with mental illness. This would yield an estimate of the number of persons with mental illness, inclusive of those with co-occurring addictive disorders, who are homeless is approximately 9,634 persons, or 30% of the total 32,112 homeless served by the shelters who reported for the 2008 survey.

The Shelter Survey is broken down by sub-population in the Table below. This sub-population breakdown relates to the primary reason a person is homeless, although it is recognized that homelessness is multifactorial, and some individuals may fall into more than one category.

Sub-population	Number	Percentage of Total
Severely mentally ill	3,927	12.23%
Chronic homeless	6,072	18.91%
Dual Diagnosed	4,942	15.39%
Substance Abuse	9,309	28.99%
Veterans	3,692	11.50%
Elderly	1,441	4.49%
Other/ Not Reported	*2,729*	*8.50%*
TOTAL	32,112	

The Projects to Assist in Transition from Homelessness (PATH) program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. Louisiana's PATH program provides a significant amount of *outreach* activity as well as other support services. The annual reports from Louisiana PATH providers for 2008 showed that 4,871 homeless persons with mental illness were served.

One of the greatest needs in Louisiana is the creation of housing that is affordable to persons living on an income level that is comparable to that of SSI recipients. That is, housing that is aimed at those individuals at and below 20% of Median Income. Supportive services necessary to assist an individual in remaining housed are also crucial. Efforts to increase available and appropriate housing for persons with mental illness through training and recruitment of housing providers and developers and development and access to support services continues to be a priority.

There are multiple providers of homeless programs in each area of the state. Each Region / LGE has a Continuum of Care for the Homeless that serves as the coordinating body for the development of housing and services to the homeless. The regional Continuums of Care incorporate a complete array of assistance for homeless clients from outreach services to placement in permanent housing. Both private and public agencies are members of these organizations. The programs provide outreach and/or shelter and housing services to the homeless, as well as substance abuse and mental health services. Services targeted to the elderly, children, youth and their families who are homeless have been generally limited in the past, however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state.

For the federal PATH funding, Louisiana relies on in-kind and contractual contributions as its federal match. For FY 09 the match amount is $345,810. Virtually all of the PATH service providers are part of the local Continuum of Care systems for the homeless. As a part of the planning process, these coalitions participate and facilitate public hearings to request comment on the current use of funding to put an end to homelessness, and provide opportunities for public comment.

The Louisiana Road Home Recovery Plan, an initiative of the Louisiana Recovery Authority (LRA) has included the rebuilding of affordable housing in the areas most impacted by Hurricanes Katrina, Rita, Gustav and Ike. This is being accomplished through a system of funding incentives that

encourage the creation of mixed income housing developments. This plan targets not only the metropolitan areas impacted by the hurricanes but also several of the rural parishes that were more impacted by hurricane Rita. Included in this plan is the use of Permanent Supportive Housing as a model for housing and supports for people with special needs, such as people with disabilities, older people with support needs, families with children/youth who have disabilities and youth aging out of foster care. It is a model that provides for housing that is fully integrated into the community. The model does this through setting aside a percentage of housing units within each housing development built to be used for persons in special population categories, and includes support services that are delivered in the individual's (or family's) home. Adults with SMI and families of children with emotional/behavioral disorders, and the frail elderly are included within the identified special needs population targeted for the supportive housing set aside units. The services to be delivered to persons/families in the target population will be those services likely to help them maintain housing stability.

Nearly 12,000 individuals remain homeless in MHSD. The Greater New Orleans Community Data Center reports that, "due to damage to the existing housing inventory and the increase in demand for the remaining units, HUD continued to increase the Fair Market Rents for the seven-parish New Orleans area. The newest numbers, effective as of October 1, 2007 indicate that the average rent has increased by more than 46% since before Hurricane Katrina. Fair market rents are estimates of gross rental prices that include the cost of all utilities except phone and cable. Taken together, the deficits in affordable housing and the drastic increase in the cost of living in the Greater New Orleans area have generated a homeless crisis. The homeless crisis disproportionately affects the chronically mentally ill, most of whom are on a fixed budget and lack support systems. Throughout the New Orleans area, thousands of people inhabit abandoned homes, nearly 500 people fill the emergency shelters every night, and there are countless numbers of individuals living from 'pillow to post' and on the street. It is noted that HUD does not consider people who are in shelters, supportive housing and FEMA housing as "homeless" and therefore numbers that include people who are *displaced from their homes* are not technically 'homeless' and these numbers are actually much greater than reflected in the HUD counts.

Clients Reporting Being Homeless as of 6/30/2009 Compared to 6/30/2008

Region/ LGE	Total number reporting homelessness as of **6/30/08**	Of total number, how many were displaced by hurricanes/ disaster **(6/30/2008)**	Total number reporting homelessness as of **6/30/09**	Of total number, how many were displaced by hurricanes/ disaster **(6/30/2009)**	Methodology used to arrive at these figures**
MHSD*	2219 (6/30/07)	1745 (6/30/07)	4423	4423	Point in time survey
CAHSD	1077	320	38,800***	unk	Annual shelter survey data
Region III	677	128	565	126	Point in time survey, HMIS Data**
Region IV	172	unk	170	unk	Contractor reporting on PATH and adult comprehensive contract
Region V	204	unk	123	unk	Point in time survey
Region VI	456	32	162	51	Point in time survey, Annual shelter survey
Region VII	1143	0	973	0	Point in time survey
Region VIII	286	n/a	276	n/a	Point in time survey
FPHSA	683	unk	379	unk	Point in time survey
JPHSA	481	432	553	434	HMIS Data

NOTES:

*** Due to the management restructuring in MHSD data was not available for the fiscal year 2008.**

****HMIS: Homeless Management Information System Data**

***** The extremely large jump in homelessness is due to the removal of FEMA housing supports**

For further discussion of related aspects of homelessness, the reader is referred to *Section III, Criterion 1, Housing Services.*

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS – RURAL ACCESS TO SERVICES
LOUISIANA FY 2010 - ADULT PLAN

A *Rural Area* has been defined by OMH using the 1990 U.S. Bureau of the Census definition: A rural area is one in which there is no city in the parish (county) with a population exceeding 50,000. Louisiana is a largely rural state, with 88% (56) of its 64 parishes considered rural by this definition. There is an OMH mental health clinic or satellite clinic in 45 of these 56 rural parishes. There is a Mental Health Rehabilitation provider located in most of the rural parishes.

Although OMH has placed many new programs in rural areas, barriers, especially transportation, continue to restrict the access of consumers to these rural mental health programs. Transportation in the rural areas of the state has long been problematic, not only for OMH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but to employment and educational opportunities. The resulting increased social isolation of many OMH clients with serious mental illness who live in these areas is a primary problem and focus of attention for OMH. Efforts to expand the number of both mental health programs and recruiting of transportation providers in rural areas are an ongoing goal.

RURAL TRANSPORTATION PROGRAMS FOR SMI / EBD 2008-2009

Region/ LGE	Type of Programs	# of Rural Programs
MHSD	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	6
CAHSD	Medicaid Transportation, City/Parish Transportation; Local Providers	31
III	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	9
IV	Medicaid Transportation, City/Parish Transportation, Local Providers	11
V	Medicaid Transportation; City/Parish Transportation; Local Providers, Other	15
VI	Medicaid Transportation, City/Parish Transportation,, Local Providers, Others	13
VII	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	23
VIII	Medicaid Transportation, City/Parish Transportation	4
FPHSA	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	28
JPHSA	*NO RURAL AREAS	0
TOTAL		**140**

RURAL MENTAL HEALTH PROGRAMS FOR SMI / EBD 2008-2009

Region/ LGE	Name/Type of Programs	# of Adult Rural Programs	# of C/Y Rural Programs
MHSD	CMHC, ACT teams, Drop-In Centers, Other	6	0
CAHSD	CMHC, Satellite Clinics, Outreach Sites, ACT teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	17	41
III	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups	8	11
IV	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	21	10
V	Satellite Clinics, Outreach Sites, Mobile Outreach, MHR Agencies, Support Groups, Other	19	11
VI	CMHC, Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR, Support Groups, Other	24	11
VII	CMHC, ACT teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups	8	6
VIII	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	30	27
FPHSA	CMHC, Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	35	15
JPHSA	Outreach Sites	0	1
TOTAL		**168**	**133**

Key: CMHC= Community Mental Health Clinic
ACT= Assertive Community Treatment Team
MHR= Medicaid Mental Health Rehabilitation Program

The capacity for telemedicine, tele-networking, and teleconferencing throughout the state has resulted in better access to the provision of mental health services in rural areas. All state hospitals and approximately almost all CMHC's have direct access. This system addition is actively used for conferencing, consultation and direct care.

In an attempt to alleviate access problems, OMH has available teleconferencing systems at 66 sites, including Mental Health clinics, ECSS sites, Mental Health Hospitals, LA Spirit, OMH regional offices, and OMH Central Office. Some sites have multiple cameras. Some of these cameras are dedicated to Telemedicine (doctor/client session) while the others are used for Teleconferencing (meetings, education, etc). The other sites use their single cameras for both Telemedicine and Teleconferencing. The sites have begun to buy High Definition Cameras per DHH regulations. These cameras provide better quality but also take up more bandwidth.

Telecommunication has become the primary mode for communication within OMH. In an average week there are 20 different meetings conducted through teleconferencing including regular meetings of the Regional and Area Management Teams, Medical Directors, Quality Council, and the Pharmacy and Therapeutics Committee. DHH is soon to have desktop video conferencing. Though this technology is not in place today, it is anticipated that it will be in full production within a year. Several offices have already placed orders for PC web cameras. The new software interface will allow participation into the existing video network from individual

desktop PCs. Sites now have the ability to do on demand conferencing inside their region. Regional Meeting rooms were setup for telemed and standard conferencing that can be launched from the sites anytime or day of the week. This is especially helpful in an emergency that happens outside normal work hours. The system is also used for training and other administrative purposes. Forensic patients at ELMHS are being linked with Tulane University psychiatrists in New Orleans through telemedicine. Telemedicine has resulted in more efficient communication between various sites across the state. Currently OMH Region 5 is using telemedicine with a physician who is stationed in France.

OMH Video Conferencing Sites - June, 2009			
	Site	**Parish**	**City**
1	Allen Mental Health Clinic	Allen	Oberlin
2	Assumption Mental Health Clinic	Assumption	Labadieville
3	Avoyelles Mental Health Clinic	Avoyelles	Marksville
4	Bastrop Mental Health Clinic	Morehouse	Bastrop
5	Beauregard Mental Health Clinic	Beauregard	DeRidder
6	CLSH (Education Room 103)	Rapides	Pineville
7	CLSH (Education Room 128)	Rapides	Pineville
8	CLSH (Admin Bldg)	Rapides	Pineville
9	Central Louisiana Mental Health Clinic	Rapides	Pineville
10	Crowley Mental Health Clinic	Acadia	Crowley
11	Delta ECSS	Richland	Delhi
12	Dr. Joseph Tyler MHC / Auditorium 1	Lafayette	Lafayette
13	Dr. Joseph Tyler MHC / Auditorium 2	Lafayette	Lafayette
14	Dr. Joseph Tyler MHC / Auditorium 3	Lafayette	Lafayette
15	Dr. Joseph Tyler MHC / Conference Room	Lafayette	Lafayette
16	ELMHS (Center Bldg.)	East Feliciana	Jackson
17	ELMHS (Clinic	East Feliciana	Jackson
18	ELMHS (Forensic)	East Feliciana	Jackson
19	ELMHS (Greenwell Springs)	East Baton Rouge	Greenwell Springs
20	Jonesboro Mental Health Clinic	Jackson	Jonesboro
21	Jonesville Mental Health Clinic	Catahoula	Jonesville
22	Lafourche Mental Health Clinic	Lafourche	Raceland
23	Lake Charles MHC / Regional	Calcasieu	Lake Charles
24	Lake Charles MHC / Room 105	Calcasieu	Lake Charles
25	Lake Charles MHC / Small Group Room	Calcasieu	Lake Charles
26	LA Spirit	East Baton Rouge	Baton Rouge
27	LA Spirit Orleans	New Orleans	Orleans
28	LA Spirit Orleans (Desktop)	New Orleans	Orleans
29	Leesville Mental Health Clinic	Vernon	Leesville
30	Mansfield Mental Health Clinic	De Soto	Mansfield

31	Mansfield Mental Health Telemed	De Soto	Mansfield
32	Many Mental Health Clinic	Sabine	Many
33	Many Mental Health Telemed	Sabine	Many
34	Minden Mental Health Clinic	Webster	Minden
35	Minden Mental Health Telemed	Webster	Minden
36	Monroe Mental Health Clinic / Auditorium	Ouachita	Monroe
37	Monroe Mental Health Clinic / Regional	Ouachita	Monroe
38	Natchitoches Mental Health Clinic	Natchitoches	Natchitoches
39	Natchitoches Mental Health Telemed	Natchitoches	Natchitoches
40	New Iberia Mental Health Clinic	Iberia	New Iberia
41	NOAH / Shervington Conference Room	Orleans	New Orleans
42	NOAH / HR Conference Room	Orleans	New Orleans
43	OMH Headquarters	East Baton Rouge	Baton Rouge
44	Opelousas Mental Health Clinic	St. Landry	Opelousas
45	Region 3 Office	Terrebonne	Houma
46	Red River Mental Health Clinic	Red River	Coushatta
47	Red River Mental Health Telemed	Red River	Coushatta
48	Richland Mental Health Clinic	Richland	Rayville
49	River Parishes Mental Health Clinic	St.John the Baptist	LaPlace
50	Ruston Mental Health Clinic	Lincoln	Ruston
51	SELH / Admin. Bldg	St. Tammany	Mandeville
52	SELH / Education Bldg	St. Tammany	Mandeville
53	SELH / Telemed	St. Tammany	Mandeville
54	SELH / Youth Services	St. Tammany	Mandeville
55	Shreveport MHC / Room 111	Caddo	Shreveport
56	Shreveport MHC / Room 145	Caddo	Shreveport
57	Shreveport MHC / System of Care	Caddo	Shreveport
58	Shreveport MHC / Room 214	Caddo	Shreveport
59	Shreveport MHC / Room 216	Caddo	Shreveport
60	South Lafourche MHC	Lafourche	Galliano
61	St. Mary Mental Health Clinic	St. Mary	Morgan City
62	St. Tammany ECSS	St. Tammany	Mandeville
63	Tallulah Mental Health Clinic	Madison	Tallulah
64	Terrebonne Mental Health Clinic	Terrebonne	Houma
65	Ville Platte Mental Health Clinic	Evangeline	Ville Platte
66	Winnsboro Mental Health Clinic	Franklin	Winnsboro

Many regions have reported that the hurricanes put a greater strain on their ability to provide services in rural areas. An increase in evacuees, a decrease in staffing, budget cuts, increased needs for medications, and more frequent emergencies have all increased the burden on existing service providers. High gasoline prices have proven to be an impediment for those seeking services especially for those living in rural areas, with their longer commuting distances.

MHSD had already been severely impacted by the 2005 hurricanes when Hurricane Gustav again interrupted service delivery. Outreach efforts have involved the newly formed ACT and FACT teams, as well as efforts to inform the community of new locations and services provided. All clinics are seeing previous clients at high levels, in addition to seeing those individuals who are temporarily in the New Orleans area rebuilding the city, including those individuals who are undocumented foreign nationals.

After the 2005 hurricanes, CAHSD established an adult mobile team with seven satellite clinic teams to serve the adult population; all mobile and satellite clinic services remain intact in all seven parishes after the 2008 storms and have increased the accessibility of our services to our clients.

FPHSA is a largely rural area north of New Orleans, and covers five parishes. After Katrina, the population in the cachement area increased, with an attendant increase in persons with mental illness. As with other rural areas, transportation is a major problem. It is not unusual to have adults and youth who need hospital services to be hospitalized as far as six hours away from their homes, since there was a decrease in available psychiatric inpatient services after the hurricanes. Region 3 notes that there is limited public transportation available in the area, and transportation is a major concern.

Programs that improve services available to persons with mental illness who live in rural areas relate to eliminating the disparities in mental health services, Goal #3 of the *President's New Freedom Commission Report*.

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS – SERVICES FOR OLDER ADULTS
LOUISIANA FY 2010 - ADULT PLAN

The Office of Mental Health recognizes that access and utilization of mental health care by older adults is an important statewide area of need, and it is imperative to place new emphasis in this area. As noted previously, the Department of Health and Hospitals now has an Office of Aging and Adult Services (OAAS). Although the OAAS is not limited to serving the mentally ill population, collaboration is the norm between OMH and OAAS. The Office of Mental Health has also been participating in a legislatively authorized Study Group on Adult Abuse and Neglect examining protective services, access to these services for both the elderly and adult populations, and legislation that impacts protective service delivery; the work of this group has already influenced service provision.

As a result of Senate Concurrent Resolution Number 80 of the 2008 Regular Session of the Louisiana Legislature, a task force was created to study and make recommendations to the Legislature concerning the current and future impact of Alzheimer's disease and related dementias on Louisiana citizens. OMH has a seat on this task force along with representatives from approximately 25 state agencies, advocacy and professional organizations and service related industries. The task force has been meeting monthly, and is due to issue a state Alzheimer's Plan by October 1, 2009. The plan is to consider the type, cost and availability of dementia services, and the capacity of the state system to care for persons with dementia. Quality of care and quality of life issues are to be emphasized in the plan through the provision of clear and coordinated services and supports to persons and families living with Alzheimer's disease and related disorders.

The Office of Mental Health will be initiating an Older Adult Initiative for fiscal year 2010. OMH has identified approximately 1,500 older adults, as defined by age 65 and older who are being served within the statewide system of care. The goal of the initiative is to have collaboration between the OMH treatment team and the primary care provider for these persons, to assure best practice of medication management and quality of life satisfaction for this subset of our system of care population. This initiative will focus on the quality and variety of preventive, therapeutic and supportive services for older adults served by OMH.

The Office of Mental Health is committed to aligning service delivery with the NASMHPD guidelines. For example, the initiative will focus on compiling and disseminating educational information about the status of programs for older persons with mental illness; informing treatment teams of current and prospective legislation and funding of services for older persons; and advocating for access to quality services for this sub-set of the population. The initial phase of the initiative will be to determine data integrity within our public statewide database. The second phase will be to work toward achieving 100% collaboration on each client between the OMH treatment teams and primary care providers. The final phase will be to evaluate quality of life issues for this population.

Activities being provided for the elderly currently include those services offered by OMH through the Louisiana Spirit (LA Spirit) Hurricane Recovery Crisis Counseling Program. The

LA Spirit program began providing services immediately after the hurricanes of 2005 and continues to provide expanded crisis services and education for survivors of Hurricane Gustav today. Louisiana Spirit services include the provision of crisis counseling and resource referral services to priority populations, including older adults. These services are funded by a grant from the FEMA Crisis Counseling program administered by SAMHSA through CMHS. In 2006, LA Spirit was granted the opportunity to provide specialized crisis counseling services (SCCS) as part of the CCP services and older adults have been one beneficiary from the enhanced services. These services include cognitive behavioral interventions that are consumer driven and utilize techniques such as problem solving, goal setting and motivational enhancement. SCCS services continue to be offered through Louisiana Spirit.

Louisiana Spirit providers have been reaching out to priority populations since September of 2005, immediately after hurricanes hit the Gulf Coast. In addition, LA Spirit Outreach Workers and Crisis Counselors have canvassed the State offering crisis counseling services to those impacted by Hurricane Gustav. Given that the elderly are considered one of the priority populations in the State, a special emphasis was placed on reaching out to this population. LA Spirit counselors have worked with entities as varied as local Councils on Aging, Senior Living and Assisted Living sites, Senior Centers, Nursing Homes, and Transitional Living Sites where many individuals have lived since being evacuated after the storms. Counselors have provided general psychosocial educational information on healthy living after a crisis or disaster, and reactions to grief, loss, and stress management to individuals and groups. During these contacts information is provided on what is 'normal' after a catastrophe, as well as signs or symptoms that more intensive or additional services would be beneficial. These contacts have also provided opportunities to educate survivors about when they may benefit from mental health screening. Additionally individuals and groups are regularly informed of the availability of local mental health, health and social services in their local area.

LA Spirit has functioned effectively as a bridge between the elderly and the communities in which they are currently residing. Louisiana Spirit completed 6,757 individual crisis counseling (ICC) sessions with adults age 65 and older between October 2008 and May 2009 (see Table in Criterion 1). 6,129 (91%) of these sessions were identified as first visits, which is the best estimator of unique individuals seen during ICC sessions. Well over half (62%) of the ICC sessions were with females and 37% were with males. Of these sessions, most were with people self-identified as black (55%) or white (41%), and 2% were American Indian. Over half of these sessions (56%) took place in people's homes, with community centers being the next most common location (19%). Approximately one in ten sessions (11%) took place at the provider location, while 7% occurred at a workplace. Well over half (59%) of the people seen during ICC sessions had experienced at least five of the 16 risk factors identified on the ICC encounter form. Almost three-fourths (72%) had experienced at least four of the risk factors. Most (96%) of the elderly adults seen during ICC sessions received at least one type of referral for additional resources or services, including additional crisis counseling program (CCP) services. The most common type of referral made was for disaster services (57%), followed by other crisis counseling services (45%). Referrals for mental health services were made during approximately one-third of ICC sessions with elderly adults (32%). Referrals for substance abuse services were made during 3% of all sessions. Referrals for other types of services were made during 6% of all sessions and include referrals to senior centers and support groups, including Councils on Aging; for medical and dental needs; for legal assistance and for assistance with rent or utilities payment.

The CCP group encounter form does not capture information about individual participants in group sessions. However, it does capture if there is a common identify among participants. Based on this information, there were 107 group sessions completed where the common identity among participants was identified as the age range of 65+ years. A total of 1,942 participants attended those group sessions. These figures are summarized in table form in Criterion 1 of this document.

The Louisiana Spirit model, as a community based approach has been in keeping with several *New Freedom Commission* goals. The program emphasizes the connection between mental health and overall health (Goal #1), and information provided has been helpful in assisting the elderly to understand this fact. Recipients of LA Spirit services have a greater appreciation of how personal health and mental health may have been impacted by the hurricanes. Rather than individuals going to sites during regular business hours, services are delivered within communities at times when survivors are available making it easier for them to access mental health services. Services have also been provided in survivors' homes. The Louisiana Spirit Crisis Counseling hurricane recovery program is consumer and family driven (Goal #2). The program's underpinning utilizes a model that incorporates crisis counseling and referral to assistance to those who would benefit from additional mental health and other services (Goal #4).

As discussed in the Housing Services Section of Criterion 1 and previously in this Criterion (see Outreach to Homeless), there are several initiatives to assist the elderly with housing. OMH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has actively pursued the inclusion of people with disabilities in the development of affordable housing. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed with Low Income Housing Tax Credits to go to low income people with special needs, including the elderly population. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative also targets the aging population so those persons with mental illness who are in that subpopulation will have targeted housing, emphasizing Goal #3 of the *President's New Freedom Commission Report*: disparities in mental health services are eliminated.

Some clinics (i.e., MHSD) have benefits specialists who work with all populations, but particularly the elderly to ensure that they receive individualized case management. Some clinics, such as Tyler Mental Health Clinic in Region 4 has assigned a registered nurse to deliver specialized health needs to the elderly population, and other regions provide enhanced nursing services for this population. In some regions, there are interagency support groups for Alzheimer's disease.

Informal collaborative agreements exist with the Federally Qualified Health Care Centers (FQHCs) regarding persons with SMI over the age of 65. Mobile outreach teams provide therapeutic respite and linkage to community services for adults. In an example of a collaborative agreement, a local hospital provides on-site medical care at the Baton Rouge Mental Health Center on a monthly basis. In addition, the Council on Aging works with clinics in the provision of food, transportation, and sitter services. Region 7 has specialized

programming for elderly that includes five geriatric inpatient psychiatric units and four geriatric day programs. Outpatient counseling is also available specifically for this population.

Specific clinical staffing and enhanced nursing services are also noted as ways of meeting the needs of elderly persons with SMI. Other specialized initiatives and relationships mentioned included home health agencies, meals on wheels, Elderly Protection Services, Senior Citizens Centers, Council on Aging, Veterans Administration, Governor's Office of Elderly Affairs and Housing Authority for Senior Citizens.

CRITERION 5
MANAGEMENT SYSTEMS – RESOURCES. STAFFING, TRAINING OF PROVIDERS
LOUISIANA FY 2010 - ADULT & CHILD/YOUTH PLAN

The Community Mental Health Block Grant for the FY 2010 and FY 2009 is $5,435,135 an 11.7% decrease from the original FY 08-09 of $6,155,074, which was decreased 2.4% from the FY 07-08 of $6,309,615 up from the low of $5,902,412 in FY 05-06; which was reduced from the FY 04-05 level of $6,338,989. Block Grant money is used by OMH to finance innovative programs that help to address service gaps and needs in every part of the state. The Block Grant funds are divided almost equally between Adult and C/Y programs. The OMH FY 2009-2010 budget (initial appropriation) was $309,468,286. The total appropriation for the community is $82,706,920.

The following tables provide additional budgetary information, including a breakdown of federal funding for mental health services. The following pages contain further information about staffing resources, etc.

OFFICE OF MENTAL HEALTH INITIAL APPROPRIATION FOR FY 09-10			
BUDGET SUB-ITEM	**SUB-ITEM DIVISIONS**	**TOTAL(S)**	**% of TOTAL**
Community Budget	CMHCs (a)	$49,830,015	16%
	Acute Units (b)	2,905,622	1%
	Social Service Contracts	29,971,333	10%
	Community Total	**$82,706,970**	**27%**
Hospital Budget	Central Louisiana State Hospital	$29,747,551	10%
	Eastern Louisiana Mental Health System (c)	105,410,060	34%
	New Orleans Adolescent Hospital (d)	-0-	0
	Southeast Louisiana Hospital (d)	51,214,466	17%
	Hospital Total	**$186,373,077**	**60%**
State Office Budget	**Central Office Total (e)**	**$40,389,299**	**13%**
TOTAL		**$309,468,286**	**100%**

(a) Excludes budgets for Capital Area Human Services District, Florida Parishes Human Services Authority, Metropolitan Human Services District and Jefferson Parish Human Services Authority.

(b) Does not include $1,250,195 for operation of the Washington-St. Tammany acute units that are located in OMH Hospitals.

(c) East Louisiana Mental Health System is comprised of East Louisiana State Hospital, Feliciana Forensic Facility, and Greenwell Springs Hospital. Budgets are combined.

(d) Southeast Louisiana Hospital and New Orleans Adolescent Hospital consolidated as of 07/01/2009.

(e) Actual appropriation is $46,248,344 of which $5,859,045 is transferred to the Community budget.

MENTAL HEALTH FACILITIES, BEDS, FUNDING
FY 2005 – 2010 (as of first day of fiscal year)

HOSPITAL SYSTEM

	FY 2005	FY 2006	FY 2007 (7/1/06)	FY 2008 (7/1/07)	FY 2009 (7/1//08)	FY 2010 (7/1/09)
Total Adult/Child State Hosp. Beds (a)	891	841	840	842	810	804
State General Funds(b) (c)($)	38,397,922	55,329,779	55,652,880	79,834,630	89,500,010	8,020,486
Federal Funds ($)	96,114,307	96,380,793	94,259,642	101,469,932	106,781,722	113,196,757

COMMUNITY SYSTEM

Acute Units

	FY 2005	FY2006	FY 2007 (7/1/06)	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)
Total Number of Acute Beds	146	209**	238	215	283	311
State General Funds ($)	0	0	0	0	0	-0-
Federal Funds ($)	13,830,179	13,582,848	7,018,005	9,429,275	5,113,592	2,905,622

NOTE: 2006 figure reflects one less acute unit that was taken over by LSUHSC (EA Conway) & 44 bed unit at GSH
2007 figures includeWOM, UMC, HPL, GSH, & WST.
2008 figures exclude GSH (transferred to ELSH).

CMHCs

	FY 2005	FY2006	FY 2007 (7/1/06)	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)
Total Number of CMHCs*	43	43	40	41	43	43
State General Funds ($)**	61,230,195	38,595,548	33,200,663	34,767,708	37,993,999	35,575,211
Federal Funds ($)	4,190,191	4,842,248	7,951,436	7,539,648	8,159,082	13,180,987

*Includes Clinics only – (including LGEs)
** does not include LGEs

CONTRACT COMMUNITY PROGRAMS	FY 2005	FY 2006	FY 2007 (7/1/06)	FY 2008 (7/1/07)	FY 2009 (7/1/08)	FY 2010 (7/1/09)
State General Funds ($)	9,630,947	7,055,555	6,063,759	12,830,006	31,144,944	28,236,120
Federal Funds ($)	5,346,843	2,472,667	23,017,891	12,871,215	3,346,292	2,221,512

NOTES:
(a) Staffed beds. Does not include money for operation of acute units in OMH freestanding psychiatric hospitals
(b) Additional services for persons with mental illness were provided through the Medicaid agency:
Mental Health Rehabilitation Option
(c) State General Funds amounting to $60,745,784 were replaced by Social Services Block Grant monies for FY 2010.

State Psychiatric Facilities Statewide Staffed Beds
(7/22/2009)

	Facility		Adult Acute Beds	Adult Civil Intermediate Beds	Adult Forensic Beds	Child and Adolescent Beds	TOTAL
OMH HOSPITALS	**Central State Hospital**		0	60	56	16	**132**
	Eastern Louisiana Mental Health System	**Jackson and Greenwell Springs Campus**	66	210	88	0	**364**
		Feliciana Forensic Facility	0	0	235	0	**235**
		Total for ELMHS	66	210	323	0	**599**
	New Orleans Adolescent hospital		12	0	0	10	**22**
	Southeast Louisiana Hospital (Mandeville, LA)		37	94	0	35	**166**
LSU-New Orleans/ Staffed by OMH	**University Medical Hospital**		20	0	0	0	**20**
	Moss Hospital		10	0	0	0	**10**
	LSU-Bogalusa-Wash St. Tammany		10	0	0	0	**10**
LSU-Shreveport Operated	**EA Conway**		26	0	0	0	**26**
	Huey P Long Hospital		16	0	0	0	**16**
	LSU- Shreveport		51	0	0	0	**51**
LSU-New Orleans Operated	**Leonard Chabert Hospital**		24	0	0	0	**24**
	Med Ctr of LA-University Campus		39	0	0	0	**39**
TOTAL STAFFED BEDS			**311**	**364**	**379**	**61**	**1115**

tc7/22/09

TOTAL NUMBERS OF HOSPITAL INTERMEDIATE CARE BEDS
BY FACILITY (6/30/09)

	Licensed	Staffed	% Staffed	% Occupancy
CLSH*	196	132	67.3%	98.4%
ELSH	362	298	82.3%	99.9%
SELH	235	235	100%	100%
FFF	102	15	14.7%	89.8%
NOAH	296	124	41.9%	95.2%
TOTAL	**1191**	**804**	--	--

*Data for Central Louisiana State Hospital available through May 31, 2009
Based from PIP Patient Population Movement Report tc

OMH WORKFORCE ON LAST DAY OF FY 2004 – 2009

Organizational Unit	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	Increase / [Decrease]
Community System: Regions & LGEs							
MHSD	106	120	154	87	107	191	84
CAHSD	118	125	163**	281**	181	142	[39]
Region 3	73	83	71	70	77	76	[1]
Region 4	129	134	126	125	131	134	3
Region 5	76	79	59	57	53	58	5
Region 6	90	106	101	96	104	95	[9]
Region 7	75	95	77	67	79	78	[1]
Region 8	62	72	73	58	62	61	[1]
FPHSA	62	66	60	94	97	80	[17]
JPHSA	67	60	70	73**	86	75	[11]
Community Sub- Total	**858**	**940**	**954**	**1,008**	**977**	**990**	**13**
OMH Operated State Hospitals							
CLSH	368	351	347	316	371	363	[8]
ELMHS	1,249	1,245	1,176	1,227	1,285	1286	1
NOAH	158	163	96	172	255	233	[22]
SELH	479	518	394	442	593	526	[67]
State Hospital Sub-Total	**2,254**	**2,277**	**2,013**	**2,157**	**2,504**	**2,408**	**[96]**
State Office*	**130**	**168**	**175**	**349***	**430****	**357*****	**[73]**
Statewide Total	**3,242**	**3,385**	**3,142**	**3,514**	**3,911**	**3,755**	**[156]**

KEY: **CLSH** = Central Louisiana State Hospital
ELMHS = Eastern Louisiana Mental Health System (ELMHS) - includes Greenwell Springs Hospital, East Division, & Forensic Division
NOAH = New Orleans Adolescent Hospital
SELH = Southeast Louisiana Hospital

NOTES: Count is of TO Positions

*The large increase in State Office numbers in 2003-06 is due to the inclusion of the staff of ECSS, Prior Authorization, and LaYes, and in FY 07 & 08 also LA Spirit.

**Includes Social Services Block Grant (SSBG) positions

***Reflects the decrease in LA Spirit, SSBG, and MHR unit staff.

Numbers of Community Professional Staff Members by Discipline on June 30, 2009

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/ PharmD
Region/LGE		Doctoral & Medical Psych	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
MHSD	14(13.5 FTE)	2 1 MP	0	0	14	1	12	0	17	2	1
CAHSD	16(8.84 FTE)	2(.45 FTE) 3 MP	0	0	96(48 FTE)	3	7	3	2(1.2 FTE)	10	0
III	12	2(1.6 FTE) 1 MP	10	1	10	1	9	4	0	0	0
IV	8(4.9 FTE)	3 (3.33 FTE) 2 MP (0.3 FTE)	6	0	32	0	0	10	2	6(4.75 FTE)	4(1.1 FTE)
V	2(1.2 FTE)	0 1 MP(0.2 FTE)	3	0	7	0	5	0	1	6(5.2 FTE)	3(.26 FTE)
VI	4	3 0 MP	5	0	9	0	5	5	1	8	0
VII	10(7.85 FTE)	2(0.6 FTE) 0 MP	0	0	14	0	3	3	9	8	0
VIII	4(2.8 FTE)	1(0.25 FTE)/ 1 MP(0.25 FTE)	0	0	19	0	2	7	9	5	1(0.8 FTE)
FPHSA	9(6.6 FTE)	1(0.1 FTE) 0 MP	0	0	39	0	2	3	3	4	2(1.4 FTE)
JPHSA	7(5.6 FTE)	2.5(1.58 FTE) 0 MP	0	0	30(28.95 FTE)	2.5	3.5	0	5.5(5.4 FTE)	7.5	.5
Total By Discipline	**86 (67 FTE)**	**19(13 FTE) / 8(6 FTE) MP**	**24**	**1**	**270(221 FTE)**	**8**	**49**	**35**	**50(49 FTE)**	**57(55 FTE)**	**12(6 FTE)**

Numbers of OMH Hospital Professional Staff Members by Discipline on June 30, 2009

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/ Doctorate
Hospital		Doctoral & Medical Psych	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
CLSH	6	4 0 MP	3	0	7	0	6	61	3	8	1
ELMHS	24	8 6 (5.5FTE) MP	3	0	44	6	84	76	8	47	13
NOAH	4	2 0 MP	0	0	19	3	18	3	2	3	0
SELH	8	10 0 MP	2	1	11	4	21	31	5	9	0
Total by Discipline	**42**	**24 6(5.5FTE) MP**	**8**	**1**	**81**	**13**	**129**	**171**	**18**	**67**	**14**

NOTES: (FTE listed only if not full-time) *** MP= Medical Psychologist**

OMH Community Total Prescribing Workforce on June 30, 2009

Psychiatric Type	Total Number FTE Psychiatrists		Of Total Psychiatry FTE, Number Certified Child Psychiatrists		Total Number FTE Medical Psychologists		Total Number FTE Nurse Practitioners	
Region/ LGE	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract
MHSD	2	4	2	2	0	0	0	0
CAHSD	11	8	2	0	0	0	1	0
3	7	3	2	0	0	0	0	0
4	4	0.9	1	.10	0	0.3	0	0
5	1.2	0	0.8	0	0.2	0	0	0
6	4	4	1	0	0	0	0	0
7	6.8	1.05	0	.65	0	0	0	0
8	2	0.8	0	0	0	0	0	0
FPHSA	5.2	1.2	1	0.8	0	0	0	0
JPHSA	9.95	1.24	2.60	.32	0	0	0	0
TOTAL	53.15	24.19	12.4	3.87	0.2	0.3	1	0

OMH Hospital Psychiatric Workforce on June 30, 2009

Psychiatric Type	Number FTE Psychiatrists Serving Adults/ Children		Number FTE Certified Child Psychiatrists		Hospital FTE Total Psychiatrists
Hospital	Civil Service	Contract	Civil Service	Contract	
CLSH	3	1	0	0.5	4
ELMHS	0	24	0	0	24
NOAH	4	6	3	3	10
SELH	8	24	2	4	32
Totals	**15**	**55**	5	7.5	**70**

KEY: CLSH = Central Louisiana State Hospital
ELMHS = Eastern Louisiana Mental Health System (ELMHS): Greenwell Springs Hospital, East Division, Forensic Division
NOAH = New Orleans Adolescent Hospital
SELH = Southeast Louisiana Hospital

OMH Community Staff Liaisons on June 30, 2009

Region/ LGE	FTE Child / Youth Family Liaisons	FTE Adult Consumer Liaisons
MHSD	1	Vacant
CAHSD	1	0.5
III	0.8	0.8
IV	0.8	Vacant
V	Vacant	0.8
VI	0.5	0.6
VII	0.5	0.5
VIII	0.5	0.5
FPHSA	Vacant	0.8
JPHSA	1	0.4

Includes civil service and contract employees

Training for the delivery of Evidence based practices (EBPs) has been a focus statewide. For instance, a series of Trainings on Dialectical Behavior Therapy was recently begun statewide, and workshops on Cognitive Behavior Therapy and Interpersonal Therapy have also been offered. In spite of the positive things happening with the workforce, the difficulty of delivering services with decreased funding and numbers of clinicians has become an urgent priority.

All Regions/ LGEs report difficulties providing necessary services due to a workforce shortage. In addition to the usual problems, the economy is putting an increasing strain on workforce delivery. Previously, it had been noted that many healthcare professionals left state government jobs or literally left Louisiana after the hurricanes, for better pay and better working conditions. A hiring freeze was instituted by Governor Bobby Jindal shortly after his inauguration in January of 2008; and with the downturn in the economy, layoffs and furloughs have become all too common in healthcare and state government in general. Workforce vacancies have affected all aspects of direct service: medical, nursing, counseling, and clerical. The shortage has had a serious effect on the number of clients seen, the length of time from first contact to psychiatric evaluation, medication management, and counseling. Louisiana had been the recipient of social service block grant (SSBG) funds post Katrina/ Rita, and the legislature did not replace these funds, so sustaining some programs at previous levels sometimes became impossible. Mobile outreach for children and youth, rural resource centers, rural case management services, transportation services, ACT services, adult triage centers, and a 23-hour observation unit all have been victims of funding cuts and lack of staff. There is a shortage of community resources to fill service gaps.

Reports from Regions/ LGEs indicate that admissions are backed up due to loss of medical and clinical staff over the last few years, coupled with an inability to find and keep qualified clinical staff, and a

reduction in available physician time. Recruitment efforts have included contacting medical recruitment agencies, advertisements in professional journals, newspapers, as well as contacting psychiatric residency and graduate school programs. To fill the gaps in prescribers, some regions have successfully contracted with non-physician prescribers, specifically, Medical Psychologists and/or Nurse Practitioners. Others have used locum tenens physicians.

Reports from the field indicate that due to budget cuts dictated by the 2009 legislative session, the workforce has been reduced. Job positions are being combined to try to compensate for the budget conditions without lessening the impact on quality centered patient care. In Region 5, the loss of 7 full time positions and several job vacancies have affected all areas of direct service. There is a serious effect on the numbers of clients seen, the length of time from first contact to psychiatric evaluation, medication management, and counseling; and there is a serious shortage of community resources to fill the service gaps.

CRITERION 5
MANAGEMENT SYSTEMS – EMERGENCY SERVICE PROVIDER TRAINING AND EMERGENCY SERVICE TRAINING TO MENTAL HEALTH PROVIDERS
LOUISIANA FY 2010 - ADULT & CHILD/YOUTH PLAN

OMH makes available a variety of mental health training to providers of emergency services, *as well as* emergency services trainings to behavioral health providers. Post Hurricanes Katrina, Rita, and most recently, Gustav, LGEs and Regions have partnered with and participated in numerous trainings with the Office of Public Health, FEMA, community agencies, and local emergency command centers. Thousands of hours of service time was given to emergency preparedness and response via medical special needs and general shelters, mobile crisis teams, and in other venues for many months following these hurricanes. After the initial response, regional 'after action' conferences were held throughout the state to review and assess the work done over the previous months. Among the lessons learned from the hurricanes, modifications to preparedness training have included better delineation of responsibilities between offices, staff/ volunteer roles, locations of services, and other technicalities. Evacuation procedures and plans have been more closely detailed in the event of a crisis. Collaboration with other state agencies, non-profit agencies, and other organizations on parish and local levels has occurred. Continuity of operations plans for all OMH facilities have been developed and discussion based tabletop meeting conducted to determine feasibility of these plans.

Effective emergency management and incident response activities encompasses a host of preparedness activities conducted on an ongoing basis, in advance of any potential incident. Preparedness involves an integrated combination of planning, procedures and protocols, training and exercises. The Division of Disaster Preparedness readies the Office of Mental Health (OMH) to respond rapidly and effectively to natural and man-made disasters, including terrorism**.** A variety of disaster related trainings are also offered to emergencies service providers, as well as emergency response trainings to behavior health providers to support efforts to strengthen the state's emergency response capabilities while reducing the psychological impact of the disaster statewide.

OMH regularly updates Call Rosters for pre-assigned personnel to staff medical special needs shelters in the event of a natural or man-made disaster, and conducts routine training and drills activating deployment procedures in these procedures. Additional required training for all OMH staff includes FEMA sponsored National Incident Management System Training (NIMS). More than 90% of OMH employees involved in emergency management have completed required NIMS training. At a minimum, all employees are required to take 2 NIMS courses. Each OMH agency has adopted plans to ensure training compliance by new hires annually. Through ongoing collaboration with OPH, OMH key emergency response personnel are engaged in activities and trainings to improve workforce readiness and response operations in Medical Special Needs Shelters and state and local Emergency Operations Centers (EOC).

The following documents activities by the Office of Mental Health and/or its affiliates. All trainings are culturally competent and age/gender-specific to the population served in alignment with Goal 1 and Goal 3 of the *President's New Freedom Commission Report*.

- Hurricane preparedness and Shelter-in-Place tabletop exercises are conducted as a training exercise with OMH hospitals and mental health clinics across the State. These drills provide a learning venue for service providers to help them better understand the impact of disasters on

persons with mental illness and to increase their skill capability to respond to emergencies in the behavioral health care community, including inpatient and outpatient environments. All trainings are culturally competent and age/gender-specific to the population served in alignment with Goal 1 and Goal 3 of the *President's New Freedom Commission Report*.

- OMH jointly with the Office of Public Health and the Governor's Office of Homeland Security and Emergency Preparedness provides ongoing training to parish level police/fire/EMS workers charged with disaster response duties, i.e., critical incident management, mental health disaster services, bio-terrorism preparedness, mental health response to mass casualties, coordination of mental health and first responders training, stress management for first responders, and Psychological First Aid training. For example, more than 300 first responders and members from various stakeholder groups attended the Psychological First Aid training offered in August 2008 and nearly 200 attended the June 2009 training.
- OMH works in partnership with key community organizations to provide training on crisis intervention techniques to first responders, and assists with outreach needs in crisis events through its federally funded crisis counseling program.
- Behavioral health trainings are provided routinely at the state Emergency Operations Center (EOC) to emergency operations personnel prior to and during a declared disaster.
- Various planning, preparedness, mitigation and recovery exercises are regularly conducted.
- In 2008, OMH regions and hospitals participated in a statewide hazmat drill involving an evacuation of the Lafayette area residents and businesses in a real time train derailment incident. In 2009, a statewide pandemic exercise was conducted in "real time" in response to and preparation for the H1N1 virus outbreak. These exercises involved all ESF branches with the ESF-8 being lead by the Office of Public Health.

Other agency sponsored services include:

- Stress management and self-care education and skill building to the first responder's network continued throughout the state, via the LA Spirit program. LA Spirit hosted a series of Disaster Mental Health training for first responders in 2008 and 2009. These ongoing trainings focus on raising awareness among first responders of psychological issues and trauma experienced during catastrophic events. Also in 2008, First Responders and Crisis Counselors were trained to use the FOCUS model in working with families of first responders.

- The Louisiana Partnership for Youth Suicide Prevention (LPYSP) is a program that is geared towards reducing child and adolescent suicide; however, adults have benefitted from the program also. In 2006, Louisiana was awarded funds under the Garrett Lee Smith Memorial Act from the Substance Abuse and Mental Health Service Administration (SAMHSA) to implement statewide youth suicide intervention and prevention strategies. Applied Suicide Intervention Specialist Training (ASIST), is one of several trainings which were initiated by this funding initiative. ASIST is a unique program that teaches a concise, face-to-face suicide intervention model that focuses on the reduction of the immediate risk of suicide. Participants in the training learn about their own attitudes concerning suicide, how to recognize and assess the risk of suicide, how to use an effective suicide intervention model, and about available community resources. ASIST is a model of suicide intervention for all gatekeepers and caregivers utilizing techniques and procedures that anyone can learn. The training is designed to increase skill levels, improve the ability to detect problems, and provide meaningful support to individuals experiencing emotional distress and serious mental health problems. The workshops are offered to educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, volunteers, and anyone else who might be interested in

adding suicide intervention to their list of skills. The program has been made available to all government agencies, consumer/advocacy agencies, emergency service providers, schools and families to help reduce the incidence of suicide in Louisiana. A 20-member training group has conducted ASIST, Safe Talk, and Suicide Talk Trainings statewide. This series of evidenced-based trainings has reached approximately 2,000 people. Through the successful development of five suicide prevention coalitions in Shreveport, Lake Charles, Lafayette, Jefferson and Baton Rouge, the Partnership assisted communities to develop competence related to suicide risk identification and prevention activities; improved local collaboration; and promoted the coordination of culturally appropriate resources and services for the prevention of suicide.

Please see Criterion 1 for information about the *Louisiana Spirit Hurricane Recovery Program*, the federally funded Crisis Counseling Assistance and Training Program, that is focused on addressing post-hurricane disaster mental health needs and other long term disaster recovery initiatives.

Although in recent years, crisis response has focused on hurricanes, the state also has worked towards developing a well-defined response plan for bioterrorism, pandemic flu, and other mass disasters. Collaborative relationships exist with local chapters of the Red Cross, Office of Homeland Security, Emergency Preparedness, the Office of Public Health, and the National Guard as well as other emergency management organizations. Regions/ LGEs have conducted statewide drills, meetings, and exercises with these entities to ensure an understanding of roles and responsibilities, operations, etc.

More specific examples of emergency services response include:

OMH provides staff members in all state-administered hospital emergency rooms. These staff members perform mental health screening as part of the admission process. OMH coordinates in-service training for emergency room doctors, nurses and other professional and para-professional staff. OMH also trains teachers and school administrators in disaster response procedures.

OMH, jointly with the Office of Emergency Preparedness, provides training to parish level police/ fire/ EMS workers charged with disaster response. Such training includes:

Critical incident management, Mental health disaster services, Bio-terrorism preparedness, Mental health response to mass casualties, Coordination of mental health and first responders, Stress management for first responders.

Regions and LGEs report that they are very engaged and involved in activities involving crisis and emergency planning, and they are linked with cooperative agreements to other agencies. First responder teams have been developed in some regions, and regions have plans and procedures for staffing medical special needs shelters in the event of a crisis that requires evacuation. Communication needs for staff have resulted in extensive uses of technology. Many staff members have been issued cell phones and blackberries that can be used in emergencies. In addition, 800 Mhz radios are available for use in disasters. Employees have access to electronic bulletin boards or websites that allow communication between staff, supervisors, and administration

Evaluation of the effectiveness of crisis response is on-going, and most recently emphasized in the response to Hurricane Gustav. Some areas of the state (i.e., Regions 3, 4, and 5) have suffered through the consequences of all four hurricanes in three years, and had an opportunity to exercise the lessons learned from the first storms. Regions were successful in making improvements in their regional

response following Katrina/ Rita, and their response to Gustav/ Ike proved to be excellent, in spite of severe damage to some of their clinics.

Crisis Intervention Training (CIT) for law enforcement has been well established in several regions/ LGEs to address behavioral health crises. Crisis Intervention Training (CIT) readies officers and dispatchers to assess and respond appropriately to calls involving adults with SMI and children with EBD. The CIT curriculum is being modified to incorporate specific components for adolescents/ youth. Many 911 emergency operators and dispatchers have been trained to provide essential information and linkages to services. Unfortunately, the recent legislative session resulted in severe budget cuts to the program.

Some regions/ LGEs have conducted specific training on co-occurring developmental disabilities and behavioral health disorders to community professionals, first responders, and emergency room (ER) staff. Continued dialogue with ER staff includes information on the utilization of community resources to maintain wellness and avoid crises

The Applied Suicide Intervention Skills Training (ASIST) that is described in Criterion 1 has resulted in trainings to suicide helpline staff, primary care physicians, contract providers, CMHC staff, and other interested stakeholders.

MHSD has provided staffing for community events, in particular, staffing the Mardi Gras crisis unit tent during the city's carnival season. However, MHSD reports that in general "New Orleans is a long way from being 'back to normal'".

INTENDED USE PLAN BY SERVICE CATEGORY
FY 2010 - ADULT PLAN

ADULT INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Central Office	Total Allocation
Adult Employment	Employment Programs; Development & Services	$59,645	$15,000	$74,645
Advisory Council Support	RAC Support	30,935	0	30,935
Assertive Community Treatment (ACT)	ACT Outreach Services	77,948	0	77,948
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support, Supported Adult Education	1,500	55,200	56,700
Consumer Liaisons	Consumer Liaisons (not in contracts)	123,020	0	123,020
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	5,278	63,484	68,762
Consumer Support Services	Consumer Initiated Programs, Consumer-Education, Community Care Resources; Community Resource Centers, Case Management; Consumer Support; Medicaid Enrollment; Support and Empowerment	614,763	457,000	1,071,763
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	21,380	0	21,380
Mental Health Treatment Services	Psycho-social Day Treatment; Forensic Program, Co-occurring Disorders Treatment	25,507	0	25,507
Planning Operations & System Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	0	185,446	185,446
Residential / Housing	Housing Development and Services; Foster Care; Group Homes Supervised Apartments; 24-hour residential Housing Support Services	226,150	0	226,150
Respite	Respite Services and Supports	0	0	0
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	114,000	114,000
Transportation	Community / Rural Transportation	17,200	0	17,200
Other Contracted Services	Comprehensive Mental Health Services; MIS Infrastructure Development; PODS (Public Outreach Depression Screening)	161,391	491,501	652,892
Other	Forensic Services			
TOTAL		**$1,364,717**	**$1,381,631**	**$2,746,348**

INTENDED USE PLAN BY SERVICE CATEGORY
FY 2010 – CHILD/YOUTH PLAN

C/ Y/ F INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Central Office	Total Allocation
Advisory Council Support	RAC Support	$31,000	0	$31,000
Assertive Community Treatment		0	0	0
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support	1,500	0	1,500
Consumer Liaisons	Consumer Liaisons (not in contracts)	43,806	$36,275	80,081
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	2,358	63,302	65,660
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	141,028	0	141,028
Family Support Services	Family Support Services; Wraparound; Family Mentoring Program; Family Support Liaison and Program; Medicaid Enrollment; Parent Mentoring; Nurse Visitation Program, Parent Liaisons, Mentoring, Community Care Resources; Rural Mobile Outreach Programs, Family Training, Therapeutic Camp	633,878	71,723	705,601
Planning Operations and Systems Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement, Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	25,008	118,946	143,954
Residential / Housing	Housing Development and Services; Foster Care; Group Homes; Supervised Apartments Housing 24-hour residential Housing Support Services	0	0	0
Respite	Respite Programs	344,569	0	344,569
School-Based Mental Health Services	School-Based Clinic; School-Based Services, School Violence Prevention	110,481	0	110,481
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	205,448	205,448
Transportation	Community / Rural Transportation	165,000	0	165,000
Other Contracted Services	Comprehensive Mental Health Services, Nurse Home Visitation Program, MIS Infrastructure Development, PODS (Public Outreach Depression Screening)	533,950	160,515	479,687
TOTAL		**$2,032,578**	**$656,209**	**$2,688,787**

INTENDED USE PLAN SUMMARY BY REGION / LGE

LOUISIANA FY 2010 - ADULT & CHILD/YOUTH PLAN

Allocation Summary by Region / Local Governing Entity/ Central Office

Region/ LGE	Adult	Child/ Youth	TOTAL
MHSD	$107,500	$321,106	$428,606
CAHSD	145,759	273,769	419,528
Region 3	169,521	203,618	373,139
Region 4	195,247	195,247	390,494
Region 5	134,115	246,044	380,159
Region 6	121,619	246,415	368,034
Region 7	147,082	179,084	326,166
Region 8	171,276	171,276	342,552
FPHSD	131,637	165,915	297,552
JPHSA	40,961	30,104	71,065
Reg/ LGE Total	**$1,364,717**	**$2,032,578**	**3,397,295**
Central Office	**$1,381,631**	**$656,209**	**$2,037,840**
TOTAL	**$2,746,348**	**$2,688,787**	**$ 5,435,135**

Percentage of Block Grant Dollars Allocated to Adults:	**50.5%**
Percentage of Block Grant Dollars Allocated to Children/ Youth :	**49.5%**

Intended Use Plan Notes

If circumstances occur that prohibit expenditure of any portion of the Block Grant funds as intended, OMH will utilize the remaining funds for the purchase of Block Grant related equipment and supplies (e.g. computers, printers, software, fax machines, projectors, tele-communication equipment/infrastructure/staff, etc.) and/or Phase IV medications and/or other appropriate expenditures.

Beginning in FY 2010, the Area budgets (Areas A, B, & C) are being folded into Central Office, since the Area structure does not exist anymore.

The allocation to the Jefferson Parish Human Services Authority appears inconsistent with other regions because when the Authority was created their Block Grant dollars were replaced with State General Funds. Since then, this situation has been considered when new Block Grant dollars have been awarded or when funding has been decreased. Starting with FY 2011, all Regions/ LGEs will move towards an equal distribution over a three year period ($1/10^{th}$ of the funding allocated) See Planning Council Activities in Part B, Section IV and Appendix for details.

Complete details of the Intended Use Plans submitted from each Region, LGE, and Central Office is included in Appendix A of this document.

Table C
MHBG FUNDING FOR TRANSFORMATION ACTIVITIES -

	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY 2010.	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	✓	N/A	$382,171
GOAL 2: Mental Health Care is Consumer and Family Driven	✓	N/A	$1,784,221
GOAL 3: Disparities in Mental Health Services are Eliminated	✓	N/A	$548,721
GOAL 4: Early Mental Health Screening, Assessment, and referral to Services are Common Practice	✓	N/A	$1,697,141
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	✓	N/A	$364,255
GOAL 6: Technology Is Used to Access Mental Health Care and Information	✓	N/A	$658,626
Total MHBG Funds		N/A	**$5,435,135**

*Goal 5 of the Final Report of the *President's New Freedom Commission on Mental Health* states: *Excellent mental Health Care is Delivered and Research is Accelerated*. CMHS is authorized to conduct evaluations of programs and not research.

DESCRIPTION OF TRANSFORMATION ACTIVITIES

NOTE: Transformation activities are prominently highlighted throughout the text of this document. Additionally, see the *New Freedom Commission & OMH Intended Use Categories Service Crosswalk* in Section II. This crosswalk highlights the efforts that Louisiana has taken to ensure that all Goals of the New Freedom Commission are addressed.

LOUISIANA FY 2010
BLOCK GRANT PLAN

Part C
STATE PLAN
Section III

PERFORMANCE INDICATORS,
GOALS, TARGETS AND ACTION PLANS

ADULT PLAN

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities **XX**

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	25,604	27,619	29,189	29,189
Numerator	--	--	--	--
Denominator	--	--	--	--

Table Descriptors:

Goal: Adults who have been identified as having serious mental illness will have access to state mental health services

Target: Access to mental health services will be provided for a greater number of adults with serious mental illness

Population: Adults diagnosed with a Serious Mental Illness

Criterion:2: Mental Health System Data Epidemiology

Indicator: The number of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. NOMS Indicator # 1

Measure: Estimated unduplicated count of adults (on caseload on the last day of the fiscal year) who have serious mental illness and who receive mental health services during the fiscal year (7/1 - 6/30) in an OMH community or inpatient setting.

Sources of Information: CMHC-ARAMIS, PIP [will be OMH-IIS in future]

Special Issues: NOTE: 1) In the past, this indicator has been reported as the percentage of prevalence of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. These numbers are discussed in Criterion 2 of the Plan. In order to be consistent with NOMS Indicators, the measure is now reported as a number rather than as a percentage. 2) Numbers reported in FY 2008 included Jefferson Parish Human Services Authority (JPHSA) for the first time, and it is hoped that from 2008 on, these numbers will be available.

The Acute Units have moved out from under the OMH umbrella into the LSUHSC system, and as a result, it is anticipated that the numbers will be reduced in the next fiscal year; however, as a target OMH will attempt to maintain the number reported for FY 2009. The population of the State has continued to fluctuate post-hurricanes, and in some areas, there has been a shortage of available services due to infrastructure and workforce problems. These factors continue to make predictions and target-setting particularly difficult. Targets continue to be set conservatively, of necessity. The FY 2009 actual figure is 29,189.

Significance: Setting quantitative goals to be achieved for the numbers of adults who are seriously mentally ill to be served in the public mental health system is a key requirement of the mental health Block Grant law

Action Plan: See Special Issues. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved access to services are a priority for Louisiana, but with the economic and workforce crisis in the state, it is important to be realistic when setting targets.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	4.8%	3.7%	5.8%	5.0%
Numerator	29	10	13	
Denominator	600	274	226	

Table Descriptors:

Goal: The Office of Mental Health will improve the quality of care that is provided.

Target: The percentage of adults who are discharged from a state hospital and then re-admitted will either decrease or be maintained (30 days).

Population: Adults diagnosed with Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of consumers discharged from state psychiatric hospitals and re-admitted to an Office of Mental Health inpatient program within thirty (30) days of discharge. NOMS Indicator #2

Measure: 30 Day Rates of Discharge and Re-admission
Numerator = # Readmits to PIP Inpatient program within 30 days
Denominator = # Patients Discharged from PIP State Hospital (not-unduplicated)
Calendar year (Jan 1 - Dec 31)

Sources of Information: Patient Information Program (PIP)

Special Issues: Comparisons from year to year are difficult given changes in data collection that seem to re-occur even when data collection is standardized and consistent. Prior to the 2007 fiscal year, the total number of discharges from state hospitals excluded patients in all Acute Units, patients on leave, Forensic (FFF) patients, and patients discharged to another state hospital. Fiscal year 2007 data included discharges from acute units *within* the hospitals, and only free-standing acute units were excluded. Beginning in FY 2008, *all* acute unit discharges (within hospital and free-standing) are excluded. These variances in data collection may explain the 2007 denominator being higher than in other years. As a result of the hurricanes in 2005, the number of available hospital beds decreased due to infrastructure and staffing problems, and the functioning of many previously stable mentally ill individuals deteriorated; thus affecting the 2006 - 2007 statistics. For example, it may be that people left the state after discharge due to problems with housing, etc. While the number of readmits has increased by 3 persons, the reduction in the denominator has made a larger impact on the actual percentage number reported. This target is again being set conservatively. FY 2009 Actual: 13 / 226 X 100 = 5.8%

Significance: Recidivism is one measure of treatment effectiveness.

Action Plan: This target will improve with the increased emphasis on the provision of EBPs in the community. A planned increase in the number of outpatient supports and services, particularly in the New Orleans area during the next fiscal year should positively impact this indicator. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana, but with the economic and workforce crisis in the state, it is important to be realistic when setting targets.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	10.67	12%	10.6%	12%
Numerator	64	33	24	
Denominator	600	274	226	

Table Descriptors:

Goal: The Office of Mental Health will improve the quality of care that is provided.

Target: The number of adults who are discharged from a state hospital and then re-admitted will either decrease or be maintained (180 days).

Population: Adults diagnosed with Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of consumers discharged from state psychiatric hospitals and re-admitted to an Office of Mental Health inpatient program within 180 days of discharge. NOMS Indicator #2

Measure: 180 Day Rates of Discharge and Re-admission
Numerator = # Readmits to PIP Inpatient program within 180 days
Denominator = # Patients Discharged from PIP State Hospital (not-unduplicated)
Calendar year (Jan 1 - Dec 31)

Sources of Information: Patient Information Program (PIP)

Special Issues: Comparisons from year to year are difficult given changes in data collection that seem to re-occur even when data collection is standardized and consistent. Prior to the 2007 fiscal year, the total number of discharges from state hospitals excluded patients in all Acute Units, patients on leave, Forensic (FFF) patients, and patients discharged to another state hospital. Fiscal year 2007 data included discharges from acute units *within* the hospitals, and only free-standing acute units were excluded. Beginning in FY 2008, *all* acute unit discharges (within hospital and free-standing) are excluded. These variances in data collection may explain the 2007 denominator being higher than in other years. As a result of the hurricanes in 2005, the number of available hospital beds decreased due to infrastructure and staffing problems, and the functioning of many previously stable mentally ill individuals deteriorated; thus affecting the 2006 - 2007 statistics. For example, it may be that people left the state after discharge due to problems with housing, etc. While the number of readmits has decreased, the reduction in the denominator has made a larger impact on the actual percentage number reported. This target is again being set conservatively.
FY 2009 Actual: 24 / 226 X 100 = 10.6%.

Significance: Recidivism is one measure of treatment effectiveness.

Action Plan: This target will improve with the emphasis on the provision of EBPs in the community. A planned increase in the number of outpatient supports and services, particularly in the New Orleans area during the next fiscal year should positively impact this indicator. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana, but with the economic and workforce crisis in the state, it is important to be realistic when setting targets.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based – Number of Practices

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	7	7	7	7
Numerator				
Denominator				

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented, and evidence-based mental health services.

Target: The number of evidence based practices (EBPs) available in the State will be maintained.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of accepted evidence-based practices offered in the State. NOMS Indicator #3.

Measure: The number of accepted EBPs offered to OMH Adult consumers in the State

Sources of Information: Annual Survey of Regions and Districts

Special Issues: There are currently seven SAMHSA accepted Adult EBPs, including: 1. Supported Housing, 2. Supported Employment, 3. Assertive Community Treatment, 4. Illness Management & Recovery, 5. Medication Management, 6. Family Psycho-education, 7. Co-occurring Disorders. Each of these EBPs is offered in some geographic areas in the state, but they are not available state-wide. Since there are seven accepted EBPs, emphasis is not so much on increasing the numbers of EBPs offered, but on increasing the Regions/ LGEs in which these services are provided. Information from the Survey is based on Region and LGE report, and EBPs are not always evaluated for fidelity. Other promising practices are being developed and offered in various areas of the state. Actual: FY 2009 = 7.

Significance: Evidence based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: **See Special Issues.** The EBPs that have been offered and that were reported on the Surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on EBPs, proper treatment focus, and accurate measurement will be emphasized. The Block Grant Indicator will be monitored through the Planning, Evaluation and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to provide improved services are a priority for Louisiana, but with the economic and workforce crisis in the state, it is important to be realistic when setting targets.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	23	68	305	305
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI who receive supported housing when appropriate as treatment goals dictate, will be maintained or increase.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Supported Housing services.
NOMS Indicator #3

Measure: Number of adults with SMI who receive Supported Housing services.

Sources of Information: Survey of Regions and Districts and Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report, and EBPs are not evaluated for fidelity. The reason for the different figures in 2007, 2008 and 2009 may have to do with the fluctuations in housing initiatives post-hurricanes, such as the FEMA housing villages, and programs such as the Road Home and LA Spirit; as well as the lack of fidelity. There has been an increased emphasis on housing since the hurricanes affected so much of the available housing stock. FY2009 Actual = 305

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

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ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	31	86	195	200
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Supported Employment will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Supported Housing services. NOMS Indicator # 3

Measure: Number of adults with SMI who are receiving Supported Employment services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. The reason for the different figures in 2007, 2008, and 2009 may have to do with the fluctuations in employment initiatives post-hurricanes; and the lack of fidelity. Supported Employment initiatives as described in the Employment section have been successful in increasing the number of persons receiving this service. Although identified as an Adult Indicator, some employment programs are available to youth seeking employment. FY 2009 Actual = 195

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

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ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	230	158	459	460
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Assertive Community Treatment will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Assertive Community Treatment services. NOMS Indicator #3

Measure: Number of adults with SMI who receive Assertive Community Treatment services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report and EBP's are not evaluated for fidelity. JPHSA began to utilize ACT services during the fiscal year, resulting in a dramatic increase in this number. In addition, statewide trainings have occurred; however, continued workforce shortages have continued to be problematic in the field. Acknowledging this, the target has been set conservatively. FY 2009 Actual = 459.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: Assertive Community Treatment is an EBP that has become a priority in the Regions and LGEs. As discussed in the FY 2009 plan, new ACT teams have been developed and have begun to operate. The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	114	192	1,417	1,500
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Family Psychoeducation will increase

Population: Adults diagnosed with a serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Family Psychoeducation. NOMS Indicator #3

Measure: Number of adults with SMI who receive Family Psychoeducation

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. There is a large increase in this number due to the EBP being offered through ELMHS. In spite of the increase, the continued workforce shortages have continued to be problematic in the field. Acknowledging this, the target has been set conservatively.
FY 2009 Actual = 1417.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	306	1,037	1,921	2,000
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Integrated Treatment of Co-Occurring Disorders - Mental Illness / Substance Abuse (MISA) will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Integrated Treatment of Co-Occurring Disorders. NOMS Indicator #3

Measure: Number of adults with SMI who receive Integrated Treatment of Co-Occurring Disorders; Mentally ill / Substance abuse (MISA)

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report, and EBP's are not evaluated for fidelity. The fidelity of this EBP is improving. The EBP that is used in Louisiana is the LITS model that has been discussed in this document. LITS has been supported by the CoSIG grant and shows to be a promising, empirically-based practice in research. LITS is similar, although not identical to the model suggested by SAMHSA. It is probable that the number fluctuated initially because many of the practices that were described were not in actuality evidence-based. With the passage of legislation merging OMH with the Office for Addictive Disorders into the Office of Behavioral Health, this number is expected to steadily increase; yet due to fiscal constraints, the target is set conservatively. FY 2009 Actual = 1921.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The consolidation of the offices of Mental Health and Addictive Disorders into the Office of Behavioral Health will improve the identification and treatment of co-occurring disorders. The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	661	1,146	3,191	3,200
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Illness Self-Management (Illness Management and Recovery) will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Illness Management and Recovery services. NOMS Indicator #3

Measure: Number of adults with SMI who receive Illness Self-Management services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report and EBP's are not evaluated for fidelity. The fidelity of this measure is improving, yet due to fiscal constraints, the target is set conservatively. FY 2009 Actual = 3191

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	5,746	1,090	8,492	8,500
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI who receive Medication Management services will increase.

Population: Adults diagnosed with serious mental illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Medication Management services.
NOMS Indicator #3

Measure: Number of adults with SMI who receive Medication Management services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals.

Special Issues: Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. This number increased dramatically in FY2007. In 2007, a policy was put into place that changed the requirements for medication informed consent, and this may have artificially reduced the number of persons who received this as an EBP in 2008, although it is apparent that the numbers of individuals receiving this EBP has dramatically increased after FY 2008. However, due to fiscal and workforce constraints, the Target is being set conservatively. FY 2009 Actual = 8,492.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. It is believed that an improved emphasis on fidelity is resulting in better data, and education on the EBPs, proper treatment focus, and accurate measurement will continue to be a focus. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	99%	99%	99%	99%
Numerator	922	1067	1394	
Denominator	927	1080	1407	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: Consumers will rate the quality and appropriateness of care they are being provided by the Office of Mental Health positively

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of Office of Mental Health consumers who rate the quality and appropriateness of services as positive. NOMS Indicator # 4

Measure: Numerator: Number of OMH consumers surveyed during the fiscal year (7/1 - 6/30) through C'est Bon process that report an overall grade of C or better. Denominator: Total number of OMH consumers surveyed.

Sources of Information: C'est Bon Survey/ MHSIP # 10, 12-16, 18-20

Special Issues: This indicator continues to hold steady, and is robust with regard to the numbers of clients surveyed. The indicator is suggested by CMHS resulting in data appropriate for national comparisons.

Definitions: C'est Bon: Consumer Evaluation of Service Team

C'est Bon Process: Consumer-to-consumer administered survey adapted from MHSIP Report Card prototype and piloted in Louisiana

The target will remain high, given the importance of this measure.

FY 2009 actual: 1394 / 1407 X 100 = 99%

Significance: Persons receiving mental health services should be satisfied with those services; and evaluation of quality and appropriateness of care are valid measures of satisfaction

Action Plan: The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Attempts to continue to obtain greater satisfaction with mental health care will remain a priority for Louisiana.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increase/ Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected/ Actual	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults served by the Office of Mental Health and who have a serious mental illness will be able to be employed and maintain their employment.

Target: A greater number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will be able to secure a job and if working, be able to retain their employment.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are capable of working and who have a job. NOMS Indicator # 5; Table 4 of URS

Measure: Numerator: Number of Persons Employed: Competitively Employed Full or Part-time (Includes Supported Employment). Unduplicated within program (community)

Denominator: [Employed: Competitively Employed Full or Part-time (includes Supported Employment) + Unemployed + Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)] Note: This excludes persons whose employment status was "Not Available".

Sources of Information: ARAMIS

Special Issues: This will be a new indicator for the state. The initial data collected will be used as a baseline. Currently, this data is primarily ascertained at admission only; and therefore, the impact of treatment at an OMH facility is not being captured. Employment programs have been severely impacted by both the hurricanes in the last several years, and the high levels of unemployment due to the economic crisis.

Significance: Measuring the number of adults with serious mental illness who are able to work and remain in the workforce, as a result of receiving mental health services, is a significant component of the Recovery movement.

Action Plan: The reporting of this information at each re-assessment/ update or discharge will need to be emphasized in order to give meaning to this Indicator. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Increased employment and retained employment are important issues that warrant a high priority, and supported employment programs are even more critical and will be promoted.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected/ Actual	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults served by the Office of Mental Health and who have serious mental illness will not require the intervention of law enforcement.

Target: A decreasing number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will be arrested over time.

Population: Adults diagnosed with Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are arrested in the year subsequent to receiving services compared to the percentage arrested in the year prior to receiving services. NOMS Indicator # 6; URS Table 19A.

Measure: Numerator: Number of people who were arrested in T1 who were not rearrested in T2 (new and continuing clients combined.

Denominator: Number of people arrested in T1 (new and continuing clients combined).

Sources of Information: MHSIP Consumer Survey

Special Issues: This is a new indicator for the state that involves reporting on changes in client status over time. OMH plans to use the Telesage Outcome Measurement System (TOMS) to accomplish this. The TOMS is scheduled for implementation in the state FY 2010 as an objective of the DIG.

Significance: Measuring the number of adults with serious mental illness who have decreasing exposure to arrest/ incarceration is a significant factor contributing to improved community function.

Action Plan: See special issues. The Block Grant indicators will be monitored through the Division of Planning, Evaluation, and Information Technology, and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected/ Actual	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults served by the Office of Mental Health will live in safe, secure, stable housing.

Target: A decreasing number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will need to use shelters for temporary residence of be homeless.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are homeless or who have been living in shelters. NOMS Indicator # 7; URS Table 15.

Measure: Numerator: Number of Persons Homeless.
Denominator: From URS Table, all persons with living situation, excluding (minus) persons with Living Situation Not Available.

Sources of Information: ARAMIS and PIP. Persons served unduplicated within and across programs.

Special Issues: This will be a new indicator for the state. The initial data collected will be used as a baseline. Currently, this data is primarily ascertained at admission only; and therefore, the impact of treatment at an OMH facility is not being captured. With the closure of many of the temporary housing communities finally occurring after the hurricanes of 2005, it is expected that homelessness will become even more problematic.

Significance: Measuring the number of adults with serious mental illness who are homeless or in shelters will assist in developing resources to provide adequate housing opportunities for individuals, a significant component of the Recovery movement.

Action Plan: The reporting of this information at each re-assessment/ update or discharge will need to be emphasized in order to give meaning to this Indicator. The Block Grant indicators will be monitored through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council. Housing stability is an important issue that warrants a high priority.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Social Supports/ Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	N/A	N/A	75%	75%
Numerator	N/A	N/A	1,057	N/A
Denominator	N/A	N/A	1,414	N/A

Table Descriptors:

Goal: Adults with severe mental illness served by the Office of Mental Health will have adequate social support.

Target: Adults with serious mental illness who report that they agree or strongly agree that they are happy with their interpersonal relationships and feelings of being connected with their community will increase.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the MHSIP consumer survey related to social connectedness. NOMS Indicator #8.

Measure: Estimated number of adults who have serious mental illness, who are receiving services during the fiscal year (7/1 – 6/30) who report that they agree or strongly agree (score 1 or 2) with statements on the MHSIP survey addressing social connectedness (#33 to 36) divided by the total number of consumers sampled, expressed as a percentage.

Sources of Information: MHSIP standard consumer survey/ C'est Bon Survey

Special Issues: This was a new indicator for the state in 2009, and as a baseline measurement, the target is set as maintaining the 2009 number. The C'est Bon survey was modified to include the full set of questions from the standard MHSIP survey for adults and has been implemented. A further enhancement to the state's consumer survey process included additional items (including social connectedness) on the C'est Bon Survey with collection beginning in July of 2008. FY 2009 Actual = 1057 / 1414 X 100 = 75%

Significance: Measuring the number of adults with serious mental illness who experience good social connectedness will be an important indicator of the prognosis for recovery.

Action Plan: The NOMS questions, including social connectedness were first included in the C'est Bon survey in July, 2008. This indicator is recognized as being important and with further data, the plan for improvement will be developed. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2087 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	N/A	N/A	76%	76%
Numerator	N/A	N/A	1068	N/A
Denominator	N/A	N/A	1414	N/A

Table Descriptors:

Goal: Adults with severe mental illness served by the Office of Mental Health will report having an improved ability to take care of themselves and independently manage their affairs.

Target: Adults with serious mental illness who report that they agree or strongly agree that they are better able to manage themselves and situations to meet their needs will increase.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the MHSIP consumer survey related to improved functioning. NOMS Indicator #9, in Development.

Measure: Estimated number of adults who have serious mental illness, who are receiving services during the fiscal year (7/1 – 6/30) who report that they agree or strongly agree (score 1 or 2) with statements on the MHSIP survey addressing functionality (#28 to 32) divided by the total number of consumers sampled, expressed as a percentage.

Sources of Information: MHSIP standard consumer survey. / C'est Bon Survey

Special Issues: This was a new indicator for the state in 2009, and as a baseline measurement, the target is set as maintaining the 2009 number. The C'est Bon survey was modified to include the full set of questions from the standard MHSIP survey for adults and has been implemented. A further enhancement to the state's consumer survey process included additional items (including level of functioning) on the C'est Bon Survey with collection beginning in July of 2008.
FY 2009 Actual = 1068 / 1414 X100 = 76%.

Significance: Measuring the number of adults with serious mental illness who experience improved functional ability will be an important indicator of the prognosis for recovery. It is also a NOMS measure.

Action Plan: The NOMS questions, including level of functioning, were first included in the C'est Bon survey in July, 2008. This indicator is recognized as being important, and with further data, the plan for improvement will be developed. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council..

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Consumer Housing/ Homeless Access (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	91%	92%	86%	86%
Numerator	422	996	635	
Denominator	465	1080	741	

Table Descriptors:

Goal: People with serious mental illness have assistance with their housing needs as part of access to appropriate, adequate mental health services

Target: Consumers who report they were satisfied with the assistance given to them by OMH in improving their housing situation will increase.

Population: Adults diagnosed with Serious Mental Illness

Criterion: 4: Targeted Services to Rural, Homeless, and Older Adult Populations

Indicator: The percentage of OMH consumers who rate the assistance they received in improving their housing with a 'C' or better.

Measure: Numerator: the number of OMH and MHR consumers surveyed who give C'est Bon Survey Questionnaire a grade of 'C' or better during the fiscal year (7/1- 6/30). Denominator: Total number of OMH and MHR consumers surveyed. (Item #24 - *How would you grade how well the services have helped you improve your housing situation?*)

Sources of Information: C'est Bon Survey

Special Issues: Due to the destruction of many homes as a result of Hurricanes Katrina and Rita, the housing situation in the state continues to be difficult to assess. Recognizing the problems with the destruction of available housing, the Planning Council initially reduced this target when the modifications were done post- hurricanes. However, the access to housing was *temporarily* relieved with the availability of FEMA trailers and rental subsidies. The numerator and denominator are noted to be different when comparing the actual statistics, due in part to difficulties hiring/ keeping consumer interviewers, costs of travel, difficulties in finding motel accommodations, etc. in the state. This has resulted in a varying sample sizes, although the performance indicator was remarkably consistent until FY 2009, given the problems with housing since the hurricanes. FY 2009 Actual: 635 / 741 X 100= 86 %

Significance: Safe, stable housing is a key factor in successful community living.

Action Plan: OMH housing coordinators are attempting to alleviate the problems encountered in each Region by improved collaboration with community and faith-based organizations. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation, and Information Technology, and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Continuity of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target
Performance Indicator	8.2	8.3	8.5	8.5
Numerator	750	631	598	
Denominator	91	76	70	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The average number of days between a consumer's discharge from a psychiatric hospital and a follow-up visit to a community mental health clinic (CMHC) will be at the lowest level possible in order to maintain continuity of care

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 2: Mental Health System Data Epidemiology

Indicator: Average number of days between a state psychiatric hospital discharge and a CMHC aftercare appointment

Measure: Days reported (excluding data from Acute Units- both free-standing & within hospital)
Average = Number of days until follow-up divided by number of discharges
Numerator = sum of days from discharge to CMHC admit
Denominator = Discharges with aftercare visit within 45 days
Time period (Lag fiscal year) - April 1 - March 31

Sources of Information: ARAMIS, PIP

Special Issues: This data now *excludes data from all acute units*. The numbers reported here for 2007 and 2008 have been adjusted to provide for accurate comparisons. In previous years reporting, the data included acute units within hospitals, because these numbers had not been separated out. At discharge, patients are routinely given 3 weeks supply of medications, so 21 days is the absolute limit for clients to be seen in the outpatient setting. Although this target was not technically met, the difference is very minor, and not particularly meaningful when comparisons are made between 8.3 days and 8.5 days. This target is being set very conservatively at a maintenance level due to budgetary and workforce constraints, including layoffs of personnel and a hiring freeze. FY 2009 Actual = 598 / 70 = 8.5 (average)

Significance: One of the strongest predictors of community success after discharge from a state hospital is continuity of care

Action Plan: Efforts to decrease the number of days between discharge and follow-up aftercare will continue to be made, and should improve with the availability of more outpatient services (as is occurring in New Orleans). The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation, and Information Technology, and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Planning Council Satisfaction (percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target **see below***
Performance Indicator	91%	100%	100%	80%
Numerator			23	--
Denominator			23	--

Table Descriptors:

Goal: Consumers, family members, and other stakeholders are involved in the policy decisions, planning, and monitoring of the mental health system

Target: Individuals who represent adults on State Planning Councils should regard and report their participation as a positive experience

Population: Adults Diagnosed with a Serious Mental Illness

Criterion: 5: Management Systems

Indicator: The percentage of Louisiana Mental Health Planning Council members giving positive feedback regarding their involvement in the Council

Measure: ***In the past, this was** the percentage of Louisiana Mental Health Planning Council members who rate their involvement in the Council with a grade of 'C' or better. Beginning with FY2010, the Planning Council voted to change this Target to **80% with a grade of 'B' or better.**

Sources of Information: Planning Council meeting evaluation surveys, Planning Council Executive Committee Reports

Special Issues: Because this indicator has been met for two years, a change was made to the measure (see above). FY 2009 Actual = 100 %.

Significance: If council members report that they are involved, it is likely that OMH is providing an environment conducive to stakeholder partnership

Action Plan: The Planning Council will continue to survey its members at each meeting and request suggestions for improvement. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation, and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Regional Advisory Councils

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected/ Actual	FY 2010 Target
Performance Indicator	100	90	100	100
Numerator	10	9	10	--
Denominator	10	10	10	--

Table Descriptors:

Goal: Consumers, family members, and other stakeholders are involved in the policy decisions, planning, and monitoring of the mental health system

Target: All local and Regional Advisory Councils will be fully constituted, trained, active, and formally linked to the Louisiana Mental Health Planning Council

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 5: Management Systems

Indicator: The percent of fully constituted and trained Regional Advisory Councils (RAC's) formally linked to the Louisiana Mental Health Planning Council.
Numerator: number of fully constituted and trained RACs formally linked to the Planning Council
Denominator: number of Regions / LGEs (10)

Measure: Count of fully constituted, trained, active Regional Advisory Councils on June 30 of the fiscal year as verified by Planning Council Regional Advisory Council training staff

Sources of Information: Regional Advisory Councils, Planning Council Executive Committee Reports, Survey of Regions & Districts, and Survey of Hospitals

Special Issues: Problems were encountered with the functioning of RACs prior to the hurricanes in 2005. The hurricanes further disrupted the situation. A further complication occurred in July of 2008 when the liaison left her position. A new liaison was hired, and this individual has been working diligently with the regions/ LGEs to have fully functioning and engaged RACs. The help offered has been warmly accepted, however, it is recognized that this is a process, and will take continued effort.

Significance: Local planning and advocacy is the cornerstone of statewide system change and progress

Action Plan: The Planning Council Liaison will continue to provide training and support to RACs, reporting to OMH and the Planning Council when there are problems. LGEs have been made aware that a RAC is necessary in order to be recipients of Block Grant funding. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.